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OVERSIGHT ON POST-TRAUMATIC STRESS DISORDER

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

JULY 14, 1988

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OVERSIGHT ON POST-TRAUMATIC STRESS DISORDER

THURSDAY, JULY 14, 1988

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-628, Dirksen Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston, Matsunaga, Mitchell, Rockefeller, Murkowski, and Simpson.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. This hearing will come to order. Good morning and welcome to each of you this morning. Today we are conducting an oversight hearing on post-traumatic stress disorder, known as PTSD. The issues we will be covering today are varied, as are our many witnesses from across the country, and our explorations will be broad in scope.

The general topics to be discussed include the prevalence of combat-related PTSD among Vietnam and other veterans; the status and future of the VA's Special Committee on PTSD; as well as the committee's recommendations and findings regarding the VA's various PTSD programs, including its National Center for Stress Recovery; various issues in regard to treatment in a variety of modes—vet centers, outpatient units, general inpatient settings, and specialized units—and the coordination, or lack thereof, of the care received in the various modes in various facilities; the need for followup care; the extent to which an unmet need for services exists; and the extent and effectiveness of coordination, as to PTSD, between the treatment side of the VA—the Department of Medicine and Surgery—and the benefits side—the Department of Veterans' Benefits.

We will also be hearing very interesting testimony from the General Accounting Office about the changes being made in treatment programs for PTSD, alcohol and drug dependencies, and other long-term psychiatric conditions in response to the VA's resource allocation methodology [RAM], a system designed to encourage increased productivity and efficiency at VA medical centers, but one which may be producing very unfortunate results from a programmatic standpoint.

I would like to say just a few words about the apparent variability of PTSD, which I believe we need to keep in mind to help put the testimony into the appropriate context. While not labeled as such until 1980, PTSD has been with us for a long time under various names; battle fatigue and shellshock are labels from previous wars for the same disorder.

It is a psychological disorder that varies in intensity, from dampening an individual's ability to participate to the fullest degree in life to total incapacitation when suicide appears to be the only hope of escape. It is a disorder which, for some veterans, has been relatively dormant for the majority of time since the traumatic event and then comes to the fore, usually brought on by another life crisis of some dimension causing significant suffering. For other veterans, it is a disorder that has haunted them every day, day in and day out, from the time of the traumatic event.

Although the criteria for a diagnosis are relatively clearcut, the varied manner in which the symptoms present themselves can make the disorder appear somewhat elusive. But let us not be misled—those who suffer from PTSD know just how real it is and how it has kept them from leading fulfilling, productive, happy lives.

I have long advocated that, because of the close connection of many cases of PTSD to traumatic events in military combat, the VA should be a leader in the diagnosis and treatment of this disorder.

The Vietnam experience study released at our May 12 hearing compared 7,924 veterans who served in Vietnam with 7,364 veterans who served elsewhere during the Vietnam era, including a 2-day physical examination and psychological evaluation given to 2,490 veterans. The CDC found that 14.7 percent of the veterans who served in Vietnam have experienced combat related post-traumatic stress disorder at some time during or after their service and that 2.2 percent of the veterans in the study had this disorder during the month before their examination. These percentages translate to approximately 461,000 and 69,000 veterans, respectively. The CDC is here with us today to testify on these findings.

We will also hear testimony from a private firm, the Research Triangle Institute [RTI], about the study it has been carrying out for the VA, as mandated by the Congress in a 1984 law I authored in the Senate, of PTSD and their other postwar psychological problems among Vietnam veterans. RTI conducted indepth face-to-face interviews averaging 3 to 5 hours in length to 3,016 individuals (interviewing for 5 hours approximately 1,600 veterans who served in the Vietnam theater, for 4 hours 750 veterans who served in the Vietnam era; but not in the theater), and for 3 hours 650 civilians with similar demographics. In addition, a subset of over 300 theater veterans and 100 era veterans underwent a followup clinical interview with an expert mental health professional. The full study is expected to be submitted to the VA on November 7, 1988.

Today, RTI will tell us that it estimates that about 15 percent ±2.6 percent of male veterans who served in the Vietnan theater are currently suffering from PTSD. This represents a current demand for services of about 740,000 of the estimated 3.14 million men who served in the Vietnam theater. Among females, the current prevalence is estimated to be about 9 percent ±2.8 percent of the estimated 7,166 women who served or about 650 cases. In the racial/ethnic subgroups of male Vietnam theater veterans, the current prevalence is much higher—approximately 19 percent ±4.5 percent or 68,000 for blacks and as high as 27 percent ±7 percent percent or approximately 45,000 for Hispanics. These figures are nothing short of shocking.

Now that we have a clearer picture of the true magnitude of the problem, we must ensure that the VA has the statutory authority, resources, and programs needed to provide treatment for the men and women who suffer from this disorder.

As to that statutory authority, these findings fully substantiate the need for the legislation I proposed in S. 2011, and the committee approved last month, to require the VA to furnish inpatient and outpatient mental health services to Vietnam veterans whom a mental health professional designated by the VA's Chief Medical Director has diagnosed, on the basis of a personal interview, as suffering from PTSD.

The thrust of this legislation would be that, if an appropriate diagnostician concludes that a Vietnam veteran had PTSD, care would be forthcoming on a priority basis without the need for a formal adjudication of service connection. Additionally, S. 2011 includes a provision that would expand the eligibility for vet center treatment to include Korean conflict and World War II veterans who seek help.

On the question of funding, the Senate yesterday passed a VA appropriation, in the HUD-Independent Agencies Appropriations Act, with the $5 million add on for VA PTSD treatment that I proposed. This is a start toward the resources needed for more effective PTSD treatment.

As to the necessary VA programs, that is what this hearing is about today.

Before we begin, I would like to note that while we are focusing today on those Vietnam veterans who are suffering from psychological problems, we need to be aware that 85 percent or more have made successful readjustments to civilian life.

We have much material to cover today and many distinguished and highly qualified witnesses to hear from. I would like to remind everyone that I must ask that each witness limit his or her oral testimony to 5 minutes so that we will have sufficient time for questions, as we have many witnesses.

We will be using the red and green lights here this morning. When you see the red light, your 5 minutes have expired. I would greatly appreciate everyone's cooperation in observing this limit. Of course, each witness' prepared statement will be printed in full in the record of this hearing.

At this point, I yield to my good friend and a very effective and fine member of this committee, Jay Rockefeller. Jay, good morning.

OPENING STATEMENT OF SENATOR ROCKEFELLER

Senator ROCKEFELLER. Good morning, Mr. Chairman, and I will adhere to the 5-minute rule. There is an awesome display of experts that are before this committee by your invitation.

Mr. Chairman, I respect so much the work that you have done over the years on PTSD. You have been working with members of this committee, as well as colleagues in both bodies of the Congress to determine the extent of the psychological problems for Vietnam veterans and what we can do about them.

Let me be parochial, if I might, for a moment and say something about my own State of West Virginia because I think it serves as a microcosm of some of the problems and observations that appear in testimony for today's hearing.

West Virginia suffered the highest combat casualty rate in Vietnam of any State. Our men were put on the frontlines and died in disproportionate numbers in service to their country. It is very clear that those who were fortunate enough to return home have brought with them the wounds and the scars that, as you said, Mr. Chairman, are a day-in and day-out affair, throughout a lifetime often.

Of the 67,000 Vietnam veterans in West Virginia, over 29,000 were in combat. Experts say that at least 7,000 of those 29,000 are suffering from PTSD. As one counselor in a vet center explained to me, these are men who have literally been invaded by this disorder. It has affected their ability to work, to hold on to their marriages, and to function in the most basic way.

Today, we again hear in no uncertain terms that PTSD is a serious disease among Vietnam veterans. In my view, we have the definitive evidence to justify responding more aggressively, more compassionately, and more effectively to this problem than we have in the past.

Again, I refer to my State, Mr. Chairman. We have four VA hospitals in West Virginia—all of them big, all of them expanding, in fact. Not one of them—not a single one of them—has a special PTSD unit equipped specifically to serve veterans with this disorder, a disease that by definition is service connected and that we are learning may affect, as you said, Mr. Chairman, a moment ago, 15 percent of Vietnam veterans.

When a vet center counselor, for example, recognizes that a veteran in West Virginia has a level of PTSD that requires inpatient treatment, he may have to work for months or even years to get that veteran admitted into a mental health program with the relevant expertise and resources. The veteran in West Virginia will have to travel to a VA hospital hundreds of miles away in another State to get that treatment.

It appears that a range of efforts needs to be considered to improve the VA system for addressing PTSD. Outreach and education have to be stepped up. Vet centers should be retained and given direction, information and resources to provide the best possible services; and in particular, the VA health care system has to make a commitment to increasing access and the quality of mental health and related services, inpatient/outpatient, and in any other form to veterans for PTSD.

I recognize, Mr. Chairman, that this takes resources, and I recognize that resources are scarce everywhere. I also should note that this committee has even very recently approved several measures that are directed at improving services for Vietnam veterans in this area.

It is clearly time for the VA to reconsider its priorities and to exert the will—the institutional will—as well as direction to meet a vastly unmet need. We must respond to the pain and to the suffering of PTSD. Thank you, Mr. Chairman.

[The prepared statement of Senator Rockefeller appears on p. 119.]

Chairman CRANSTON. Thank you very much, Jay, and I appreciate your concern about this very important matter.

We now have a panel consisting of Dr. William E. Schlenger, and Dr. Richard A. Kulka, coprincipal investigators of the Research Triangle Institute; Dr. Vernon N. Houk, Director, Center for Environmental Health and Injury Control, Centers for Disease Control, accompanied by Dr. Robin Morris, associate professor of psychology, Georgia State University; Dr. Roger Hamada, research associate, Veterans' Administration Regional Office, Honolulu, HI; David P. Baine, Associate Director, Human Resources Division, accompanied by Bruce Layton, evaluator, Human Resources Division, and Mr. Gary Ulrich, evaluator, San Francisco Regional Office, U.S. General Accounting Office.

Let me note that Senator Matsunaga regrets that he will be detained for a while and won't be able to hear the testimony from the first panel of witnesses. He nevertheless extends his welcome to each of you and especially to Dr. Hamada, who appears at Senator Matsunaga's request.

As we proceed, other members of the committee may or may not be present. Although they are all deeply interested in this, we all have conflicting requirements for our time. I assure you that the committee will be doing all it can to see that we give constructive leadership and assistance in dealing with PTSD.

Dr. Schlenger, will you now, please, begin?

STATEMENT OF DR. WILLIAM E. SCHLENGER, AND DR. RICHARD A. KULKA, CO-PRINCIPAL INVESTIGATORS, RESEARCH TRIANGLE INSTITUTE

Dr. SCHLENGER. Mr. Chairman and members of the committee, on behalf of the principal investigators of the national Vietnam veterans readjustment study, I want to thank you for this opportunity to present findings from this congressionally mandated study.

The major goal of the readjustment study was to provide definitive information on the prevalence of post-traumatic stress disorder and other postwar psychological problems among Vietnam veterans. The readjustment study addressed this goal and a broad array of other objectives through a sophisticated national study of the mental health needs of all veterans who served in the Vietnam theater.

This included males and females; young and old; officers and enlisted; blacks, Hispanics, whites, and others; and veterans from all branches of the armed services. A multitiered research design was used.

We reviewed over 250,000 military personnel records to ensure that the study sample was representative of all of those who served in the war. Then, in homes scattered throughout the 50 States and Puerto Rico, we conducted over 3,000 face-to-face interviews, averaging 3 to 5 hours in length.

We studied Vietnam theater veterans, other Vietnam era veterans, and nonveterans. We included two separate clinical substudies designed to calibrate and validate our measures of PTSD. Finally, we also interviewed over 450 spouses of Vietnam veterans.

Because the heart of the readjustment study was the assessment of PTSD, we took extra care to assure the accuracy of the PTSD diagnosis. We used the current version of the American Psychiatric Association's official definition and diagnostic criteria for PTSD. This is the same definition used by the Veterans' Administration.

We also employed multiple methods of PTSD assessment, and we built in a number of quality control checks on the PTSD diagnosis.

First, we conducted a clinical substudy to identify the best PTSD measures to include in the national survey. Next, as an additional quality control check, we included a second clinical substudy in which a subsample of over 400 veterans was interviewed by expert mental health clinicians.

As a result of these and other quality control efforts, the readjustment study provided a comprehensive profile of indicators to make the diagnosis of PTSD. Thus, unlike prior epidemiological studies of PTSD, the readjustment study was not forced to rely on a single diagnostic indicator.

Based on readjustment study findings, we estimate that 15 percent of all male Vietnam theater veterans are current cases of PTSD. This means that approximately 470,000 men are afflicted with this disorder today.

Current prevalence rates among black and Hispanic men are even higher—about 19 percent among blacks and over 20 percent among Hispanics. Among female theater veterans, we estimate that 9 percent are current cases of PTSD.

Further, for all theater veterans, those who were most intensely involved in the action of the war are 3 to 5 times more likely to suffer from PTSD today than those who were less directly involved.

We recognize that our estimate of 15 percent differs markedly from the 2-percent estimate recently published by our colleagues at the Centers for Disease Control. We would like to make several points that may be helpful in understanding this difference.

First, the CDC study had as its explicit focus the physical health of Vietnam veterans; and although it contained a rigorous physical health clinical examination, its PTSD prevalence estimate was based on a single indicator of PTSD. The readjustment study, on the other hand, had as its explicit focus the assessment of PTSD and other mental health problems, contained multiple PTSD measures, including a rigorous mental health clinical examination.

Thus, the studies differed in the focus of their major quality control efforts. The studies also differed in the population sample and in the methods for assessing PTSD. Analyses conducted with our data to compare the readjustment study and the CDC study samples suggests that the discrepancy in prevalence rates is not due to differences in the population studied. Other analyses suggest that the discrepancy in prevalence rates is largely due to the ways in which the PTSD diagnosis was made in the two studies.

Therefore, we believe that the CDC Vietnam experience study provides the best available information on the physical health status of Vietnam veterans and that the readjustment study provides the best information on their mental health status.

This concludes our summary remarks, and we will be happy to answer your questions.

Chairman CRANSTON. Thank you very much. Dr. Houk, if you would now testify?

[The prepared statement of the Research Triangle Institute appears on p. 127.]

STATEMENT OF DR. VERNON N. HOUK, DIRECTOR, CENTER FOR ENVIRONMENTAL HEALTH AND INJURY CONTROL, CENTERS FOR DISEASE CONTROL, ACCOMPANIED BY DR. ROBIN MORRIS, ASSOCIATE PROFESSOR OF PSYCHOLOGY, GEORGIA STATE UNIVERSITY

Dr. HOUK. Good morning, Mr. Chairman. As you stated, with me this morning is Dr. Robin Morris, who is a consultant.

The general design and findings of the Vietnam experience study were presented to your committee on May 12. Post-traumatic stress disorder was evaluated as part of the psychological evaluation of a subsample of veterans who participated in the examination component of the study.

Post-traumatic stress disorder [PTSD] was established by using the diagnostic interview schedule of the DIS, which is a standardized questionnaire using criteria established by the American Psychiatric Association. This was administered by specially trained psychology technicians under the supervision of clinical psychologists.

PTSD due to any cause was found to have occurred in 16.5 percent of the Vietnam veterans and 3.2 percent of the non-Vietnam veterans. As we stated, 14.7 percent of the Vietnam veterans experienced combat-related PTSD at some time during or after military service.

During the month before examination, or up to 20 years after service in Vietnam, 2.2 percent met the full diagnostic criteria we use for PTSD related to combat. Nearly half reported developing symptoms the same day the traumatic event occurred; 81 percent developed symptoms within 6 months. Only 4 percent developed symptoms more than 3 years after the event.

About 60 percent indicated that the PTSD symptoms interfered with their life "a lot." Of the affected veterans, 37 percent had sought care; and about one-fourth had taken medications more than once related to the symptoms.

The findings also indicate that the elevated prevalence of anxiety, depression, and alcoholism, which were reported previously, are concentrated in but not exclusive to Vietnam veterans who meet the criteria for combat-related PTSD. The lifetime prevalence of PTSD was 20 percent among veterans with a tactical military occupational specialty [MOS], which included infantrymen, artillerymen, armored vehicle crewmen, combat engineers, and 12 percent among the nontactical MOS's.

As part of the psychological evaluations, we also administered the Minnesota multiphase personality inventory, or the MMPI. There is no standard MMPI clinical scale for identifying persons with PTSD; however, there is a single research scale developed by Keene & Associates which has been shown to discriminate hospitalized patients with PTSD from other Veterans' Administration patients.

Using Keene's scale, we found 8.8 percent of the non-Vietnam veterans and 2.8 percent of the Vietnam veterans with post-traumatic stress disorder, remarkably similar to the 2.2 percent determined by the DIS results for the current prevalence of combat-related PTSD.

Now, I will address the specific questions you asked in your letter of invitation.

The diagnostic criteria and the methodology are presented above in summary of the results. In our primary analysis, the diagnosis of PTSD was based upon the DIS, which uses the DSM-III (Diagnostic and Statistical Manual of Mental Disorders: Third Edition) criteria. We have attached a copy of those criteria to our prepared statement.

In our study, all four criteria had to be met for diagnosis of PTSD. In comparison to the diagnostic criteria used by the Veterans' Administration, it is our understanding that they now use the 1987 revision of the DSM-III, referred to as DSM-III-R, which is generally similar to the criteria that were used in 1985 and 1986, at the time of the Vietnam experience study.

The differences between these two versions are detailed in our written statement.

We have had discussions with researchers at Research Triangle Institute regarding their diagnostic criteria. It is our understanding that their study used their own modifications of the DIS, the MMPI, in addition to clinical psychiatric interviews.

We are not certain how their determination compares with the criteria we used. We have, however, provided them with the questionnaires and diagnostic criteria we used so that they could analyze their data compared to ours. We defer to them regarding the specific details of those analyses.

As for the overall significance of the findings, we mentioned in our testimony of May 12 that we feel it is important that, as recently as the month before examination, 2.2 percent of the Vietnam veterans had combat-related PTSD. Since the study is a random sample of Army enlisted veterans, the results indicate that a significant number of the Vietnam veterans are still experiencing combat-related PTSD some 15 or 20 years after military service.

Finally, Mr. Chairman, as you well know, I have been involved in the issue of the Vietnam veterans' health since 1978. When one looks at the psychological studies that are available, there is remarkable consistency across the board. Whether the number is 2 percent or 15 percent is dependent upon the diagnostic criteria used. Any number, however, indicates that a very significant number of Vietnam veterans do have this syndrome and do need care for it. Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much. At this point, we will turn to Senator Frank Murkowski, former chairman of this committee and ranking member of the committee, who has to leave very soon. He has a brief opening statement to make.

[The prepared statement of Dr. Houk appears on p. 222.]

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator **Murkowski**. I appreciate that, Mr. Chairman. You are very kind to accommodate me, and I apologize; but as usual, we have several things going on at once. I don't want to take a lot of time because you have a long and very distinguished group of witnesses.

I just want to commend the VA for the job that I think they are doing in providing treatment for veterans with PTSD. I must add that I think it is very unfortunate that the media and even some members of Congress appear to make it a habit of reporting false and sensational information about Vietnam veterans.

I think those reports foster a perception that is simply not true of most of our Vietnam veterans. I am certainly offended, as I know many of you are, by articles that appear and television programs that portray the Vietnam veteran as a maladjusted, angry, drug and alcohol abusing, underemployed, unemployable person—a loser.

The facts just don't support that, as the panel suggests. There simply are no studies and there are no data to support these negative assertions. Although they may be well intended, these negative images, I think, do a great disservice to Vietnam veterans and their families.

And I think it is time it stopped. For example, in the latest figures we have available, unemployment rates for example for Vietnam era veterans in June 1988 is 3.3 percent; that is one-half of 1 percent lower than nonveterans.

I have an extensive statement, Mr. Chairman, but I would ask that my statement be entered into the record.

Along these lines I would like to commend Butch Joeckel, who is no stranger to most of us, the national adjutant for the Disabled American Veterans. He authored an article which appeared in the July 1988 issue of the Disabled American Veterans DAV magazine, which discussed the negative stereotype associated with the Vietnam veterans in a very articulate manner. I would certainly commend that article to all of you.

I want to thank you, Mr. Chairman, and I look forward to reviewing the testimony from the witnesses. And please allow me to be excused.

Chairman **Cranston**. Thank you very much, Frank, for your brevity and especially for your concerns. Our next witness is Roger Hamada.

[The prepared statement of Senator Murkowski appears on p. 121.]

STATEMENT OF DR. ROGER HAMADA, CLINICAL PSYCHOLOGIST AND RESEARCH ASSOCIATE, VETERANS' ADMINISTRATION OUTPATIENT CLINIC, HONOLULU, HI

Dr. **Hamada**. Thank you very much, Mr. Chairman. Mr. Chairman and distinguished members of the committee, I am here today to describe and share with you observations made by researchers at the Stress Disorders Research Laboratory of the Honolulu Veterans' Administration Outpatient Clinic concerning combat-related

PTSD among Asian-American and Pacific islander Vietnam veterans.

I will also argue that enhanced cultural sensitivity within the VA is critical to identifying, understanding, treating, and preventing the deleterious impact of combat on ethnic minority veterans. Asian-American and Pacific islander peoples have a proud tradition of service to their country. The loyalty and sacrifices of the 442d Combat Regiment during World War II, which was composed primarily of Asian-Americans, and of which the Honorable Senators Matsunaga and Inouye were distinguished members, are well recognized.

During the Vietnam era, more than 85,000 American servicemen and women were Asian Pacific islanders. Almost 65 percent of these live in California and Hawaii—about 35,000 in California, about 19,000 in Hawaii. Asian-American and Pacific Islander veterans comprise 69 percent of the veteran population in Hawaii.

However, clinicians in Hawaii who treat veterans with PTSD report that Asian and Pacific islander Americans are markedly underrepresented among the veterans seeking their help. Formal data about whether Asian Pacific islander Vietnam veterans do, in fact, underutilize services and, if so, why are to our knowledge unavailable.

To our knowledge, VA service utilization statistics either are not broken down by ethnicity of the utilizer or do not provide a category for Asian Pacific islanders. Major epidemiological studies of the prevalence of mental disorder among Vietnam veterans, whose authors are here today, have either not examined ethnicity as a factor in PTSD or have oversampled blacks and Hispanics but not Asian Pacific islanders.

Reliable data on the prevalence of combat-related disturbance among veterans of Asian Pacific islander ethnicity are sadly lacking. The little evidence which is available suggests that service underutilization does not necessarily reflect absence of distress.

Data from the national Vietnam veterans readjustment study indicate that ethnic minority status is associated with higher prevalence of clinical levels of PTSD among black and Hispanic Vietnam theater veterans. Additionally, the accounts of Pacific islander veterans obtained in our own research in Hawaii strongly suggest that these veterans have experienced Vietnam-related stresses unique to their ethnicity over and above those experienced by veterans of other ethnic groups.

Asian-American veterans have reported intense guilt and trauma associated with the deaths of Vietnamese women and children whom they identified with their own mothers and siblings. Young Asian-American soldiers who considered themselves full fledged Americans were embittered when brother American veterans pointed them out as "gooks," assumed that they did not understand English, and shot at them when mistaking them for Vietnamese. Ethnicity-related traumas continued even after the war.

Dr. Cole Lew, formerly of the San Francisco Veterans Center, tells how some of his Asian-American clients in San Francisco were scorned and called "gooks" by brother veterans when they came to vet centers for assistance or when they visited the replica of the Vietnam Memorial.

This clinical evidence argues that significant numbers of Asian Pacific islander veterans do suffer combat-related post-traumatic stress symptoms. We now need more objective and comprehensive data which address this issue. Such data could be obtained in an epidemiological study of PTSD among Asian Pacific islander veterans, such as that called for by Senator Matsunaga in Senate bill 2521.

Successful completion of such a study would not only contribute significantly to understanding PTSD among Asian Pacific islander Vietnam veterans and promote their receiving needed services, but also stand as a landmark accomplishment in cross-cultural research.

Awareness of and sensitivity to cultural factors are just as critical in the treatment of PTSD efforts, such as the VA Neighborhood Clinic in east Los Angeles, which provides bilingual and bicultural services to a predominantly Mexican-American community. That should be encouraged, supported, and evaluated.

In summary, Mr. Chairman, individual experiences in Vietnam and life after Vietnam should be interpreted through ethnic and cultural lenses. It is important that ethnic and cultural factors be recognized as significant influences on how veterans manifest the effects of combat-related stress and how they cope or fail to cope with that stress.

There is some evidence of culturally sensitive research and treatment of black and Hispanic veterans within the VA. Mr. Chairman and members of the committee, I respectfully ask you to ensure that the unique problems and needs of the Asian Pacific islander Vietnam veterans receive similar formal attention and recognition. Thank you.

Chairman CRANSTON. Thank you. We will now go to questions.

[The prepared statement of Dr. Hamada appears on p. 233.]

Chairman CRANSTON. Dr. Schlenger, the estimate you have provided of the number of Vietnam veterans currently suffering from PTSD is very startling. Are you confident this estimate is correct and accurate? And if so, what is the basis for your confidence?

Dr. SCHLENGER. Mr. Chairman, we are highly confident of the accuracy of our estimate; and we make that statement on the basis of the careful quality control efforts that went into the formulation of the diagnosis. In the readjustment study, the diagnosis of PTSD was double validated; that is, two components were used to assess the validity of the diagnosis.

We started with a preliminary validation study in which we examined known cases of PTSD; this was an important and necessary first step in the validation of our measures, but did not tell the full story.

To get the full story, we included a second clinical substudy that provided the information needed for a convergence-of-indicators method for making the diagnosis. This convergence-of-indicators method enables us to have confirmation of the diagnosis; that is, no one in the readjustment study gets the diagnosis of PTSD unless it was confirmed by at least three indicators. In fact, for 87 percent of the cases, four or five primary indicators agreed on the diagnosis.

It is this convergence method and the inherent confirmation of the diagnosis that is involved that gives us confidence.

Chairman CRANSTON. As you know, the recently released Vietnam experience study, carried out by the Centers for Disease Control, found that 2.2 percent of Vietnam veterans in the study were suffering from PTSD in the month prior to the examination. Your estimate that 15 percent of the male Vietnam theater veterans are currently suffering from PTSD is very much different. Can you explain that discrepancy?

Dr. KULKA. Mr. Chairman, we were as alarmed and startled as anyone else by the discrepancy between our findings and those of the CDC and have spent considerable time trying to understand the differences and what might cause those differences.

In the past few weeks, in addition to confirming the estimate that we have presented, we did some analyses in which we examined the two major potential factors that we felt might account for this difference.

First, as you will recall, the CDC Vietnam experience study consisted of Army male veterans in the E-1 to E-5 ranks who also served only one term of service. In contrast, the readjustment study included all veterans who served in Vietnam, with the exception of those currently still on active duty.

Therefore, a marked difference in samples might have accounted for the difference in estimates. However, since the readjustment study sample contains as a subset the same sample as used by CDC, we were able to make comparisons between these.

In making those comparisons, we found very few differences, including no differences in the actual estimate, using our methodology, between the subsample that represents the same population as interviewed by the Centers for Disease Control and our total population. So, therefore, we feel that the data would suggest that the difference we observed is not due to differences in measures.

A second potential issue, which has been raised by Dr. Schlenger's answer to the first question, is differences in instrumentation. He described a multiple-method approach used by us in our study and the validity studies used to develop that approach.

The Centers for Disease Control Vietnam experience study, in their primary report, was forced to rely on one indicator of post-traumatic stress disorder, as described in the opening statement, that is, the diagnostic interview survey, or the DIS.

We, too, included—because the DIS was considered state of the art in survey research at that time—and still is, largely so—a DIS-type measure. Our DIS-type measure, however——

Chairman CRANSTON. May I interrupt you for a moment?

Dr. KULKA. Yes.

Chairman CRANSTON. There is a rollcall vote in a moment, and I am going to have to leave; and I presume Jay is also. Jon Steinberg, the committee counsel, will carry on until we get back. Thank you very much.

Mr. STEINBERG. Please continue.

Dr. KULKA. We also included a DIS-type measure. I say "DIS-type" because, based on the advice of consultants that we used early in the study, who had certain concerns about the way the standard DIS instrumentation for post-traumatic stress disorder per se were done, a somewhat different measure was developed. In addition, we felt it necessary, given the timing of our study, to try to have our instrument match the DSM-III-R criteria, which were mentioned earlier.

So, therefore, we found it necessary to make some revisions to the original DIS instrument. As a result, our revised DIS-type instrument was used in a validation study; and the validation study consisted of comparisons with known cases of PTSD—those who were receiving treatment under the VA system—and some other cases known not to be suffering from PTSD.

That measure did quite well in the initial test. We therefore carried that measure over, along with others that have been alluded to, into the main study. Using that measure, in the last few weeks, we have come up with estimates of current PTSD prevalence of approximately 3 to 4 percent; and we further refined our analysis of this by mimicking, as much as possible, based on the instruments that were provided to us by CDC, the exact items and scoring algorithm used to develop that diagnosis.

It is not an exact match; so the comparison is only approximate. However, that refinement brought our estimate down to about 1.4 to 2.1 percent, virtually identical to the information provided by the CDC in their earlier report.

However, as Dr. Schlenger noted, we also had a second validation component. Unfortunately—and I say unfortunately because we had invested a lot in our DIS-type measure as well—our analysis in that second, followup study showed very little correspondence between that measure and clinical diagnosis of PTSD as established by clinicians as part of the main study.

Therefore, it is our opinion that the low current prevalence estimate from the Vietnam experience study results primarily from reliance on an instrument which is not sufficiently sensitive to detect true PTSD cases in a community population, meaning a population that is not seeking treatment within the VA or any other mental-health-care system.

Mr. STEINBERG. Dr. Houk, could you comment on the explanation that we have gotten from RTI as to why the results of their study are different from CDC's VES findings with respect to PTSD prevalence, both what they testified to this morning and what they have in the report, which I believe you had an opportunity to look at, on pages 31 through 39.

Dr. HOUK. Yes. I saw their testimony last night, Mr. Steinberg. First of all, let me correct what was a misstatement. The Vietnam experience study was not exclusively limited to the physical health of the veterans. There was a very concerted effort to provide a psychological evaluation of these people; a lot of consultants, a lot of people, including OTA, reviewed those and made sure.

Mr. STEINBERG. We are certainly aware of that. Senator Cranston indeed, in his prepared opening statement, makes reference to that.

Dr. HOUK. We used at that time the best standardized instrument that was available, the DSM-III and the DIS; 2.2 percent of those evaluated met the very rigorous criteria of having post-traumatic stress disorder within a month of that examination. I believe, using our same criteria in the evaluation that RTI did, they came up with the same kind of a percentage.

Using Dr. Keene's scale on the MMPI, we also have around 2 percent. I think the important point here is you will have different percentages depending upon different criteria used. Whether it is 15 or 2 percent, in my view, it is not the major issue. Even at 2 percent, there is a significant number of people out there who served their country in Vietnam who need some help.

The vast majority of the Vietnam veterans are very productive members of society, Senator as Murkowski said in his statement. Two weeks ago—I believe it was—Newsweek magazine indicated that 50 percent of the prisoners in the prisons of this country are Vietnam veterans. The facts simply don't substantiate that; that is an outrageous statement. Fifty percent are not there.

Mr. STEINBERG. Dr. Houk, do you or Dr. Morris have any reason to believe that RTI's methodology was flawed insofar as the scale on which it measured PTSD?

Dr. MORRIS. Not at this time. We haven't had a lot of time to review that. Our review of their methodology suggests that we wish it had been done before our study had been done, and we could have then used parts of it.

We have no trouble with their analysis; and in fact the analysis tells us what we thought ahead of time, that the DIS was a very rigid criterion for PTSD, and that the cases we have identified are very severe cases. This estimate that they have is not out of line with some other indices that we have within our data suggesting that we have higher rates of problems than necessarily 2.2 percent.

Mr. STEINBERG. You also had some findings with respect to subclinical PTSD, where there was the presence of one or more symptoms of PTSD, but not a sufficient number of symptoms to meet the DIS criterion?

Dr. MORRIS. That is correct.

Mr. STEINBERG. What was that percentage with respect to individuals within 2 months of the interview?

Dr. MORRIS. We had 21 percent of the veterans from Vietnam who had at least one of the symptoms from the PTSD category.

Mr. STEINBERG. Is that lifetime?

Dr. MORRIS. Within the past month.

Mr. STEINBERG. Within the past month?

Dr. MORRIS. That is correct.

Mr. STEINBERG. So, somewhere in there is where the figures converge.

Dr. MORRIS. That is right. Even if you look at the most primary symptom, which is the reexperiencing symptom, we had 9.7 percent of the veterans within the last month who have had experiences of reexperiencing this trauma. So, we have no trouble with the estimates provided to us by RTI; and I think they have done an interesting analysis comparing our results, and it has to do with where the criteria are cut and how you look at it.

Mr. STEINBERG. Would you be able to give us a further response for the record after you have had a greater opportunity to study the RTI report, Dr. Houk?

Dr. HOUK. Yes. In addition, Mr. Steinberg, within the month, the several thousand page volume on psychological studies will be printed and delivered to the committee.

[Subsequently, Dr. Houk furnished the following information:]

Upon further review the current RTI report does not provide enough information for a thorough evaluation. CDC will provide a response for the record after a review of RTI's final, more detailed report scheduled for October 1988.

Dr. HOUK. As I said earlier, when one looks at all the psychological studies that are available—the True paper, the RTI, and ours—there is a remarkable consistency among the findings of the individual symptoms. Whether you add 14 of them to call it post-traumatic stress disorder or three of them to call it that, I think is relatively irrelevant.

But there are very consistent findings in all of the studies done by different methodologies, different people, with different purposes.

Mr. STEINBERG. Would you make a copy of that detailed volume available directly to Dr. Schlenger and Dr. Kulka as soon as it is available?

Dr. HOUK. Yes.

Mr. STEINBERG. So that they can supplement their comments for the committee, and would you be willing to do that, Dr. Schlenger?

Dr. SCHLENGER. Yes, sir.

Mr. STEINBERG. Dr. Schlenger, you didn't provide this morning figures indicating the lifetime prevalence of PTSD which the VES study reported was 14.7 percent—estimates that is of the number of Vietnam veterans who ever had PTSD. Could you give us such an estimate at this point? Or do you have those data available?

Dr. KULKA. Mr. Chairman, we spent virtually all our time in the past few weeks toward deriving a current prevalence estimate with great care. We certainly wanted to come in and say we had great confidence in that estimate, whatever number turned out to be. We deferred temporarily expending that same level of care on our lifetime prevalence estimate.

So, we would prefer not to provide that estimate at this time; but we would certainly make that available as soon as we are able to achieve the same level of confidence in that estimate.

Mr. STEINBERG. Do you think that will be available prior to November 7, which is the date as I understand it when you are submitting the final report?

Dr. KULKA. Yes.

Mr. STEINBERG. Thank you. If you would do that, Dr. Kulka, and submit it to the committee, we would very much appreciate it.

Dr. HOUK. Mr. Steinberg, it would be useful also if RTI did the analysis of the time of occurrence; one of the findings of ours was of people who ever had it. Only 4 percent developed it 3 years after the traumatic event.

Mr. STEINBERG. Only 4 percent of the 15 percent?

Dr. HOUK. Yes.

Mr. STEINBERG. Or 4 points of the 15 points?

Dr. HOUK. That is right. Four percent developed it more than 3 years after the traumatic event; and I think that is an important finding for the Congress, and it would be nice to see what their analysis of those data look like also.

Mr. STEINBERG. To be perfectly clear, in other words, approximately 25 percent of those—4 of 15—who eventually developed PTSD developed it within 3 years?

Dr. HOUK. Ninety-six percent developed it within 3 years of the traumatic event; 4 percent developed it after more than 3 years.

Mr. STEINBERG. So, you are saying 4 percent of the total number who developed it?

Dr. HOUK. Right, yes.

Mr. STEINBERG. Is that agreeable, Dr. Schlenger, for you to do that as well?

Dr. SCHLENGER. Yes.

Mr. STEINBERG. And Dr. Houk, after you study the RTI report to this point, if there are things you would like to suggest for further followup, would you communicate those to us? And we will, of course, request that RTI proceed in that fashion.

Dr. HOUK. Yes.

Mr. STEINBERG. Did your study, Dr. Schlenger, as did the VES, compile data on Vietnam veterans with subclinical PTSD, such as the VA refers to on page 3 of its statement, where there is evidence of "impairment of functioning on the job or in the family?" I believe those were the data that Dr. Houk referred to a few moments ago at the 21-percent level.

Dr. SCHLENGER. Yes, Mr. Steinberg. The readjustment study did collect data which would allow us to make an estimate of the prevalence of what we might call subclinical PTSD. It is important to keep in mind that our estimate of 15 percent is an estimate of the proportion who meet the full criteria as defined by the American Psychiatric Association.

We are able to make an estimate of the number of subclinical cases; we have not yet done so but intend to do so, and that estimate will be included in the report submitted on November 7.

Mr. STEINBERG. If that is available prior to that point, would you please communicate it to us?

Dr. SCHLENGER. Yes.

Mr. STEINBERG. But let me stress that we do not want you to make a special effort to isolate either that figure or the lifetime figure because we think it is important that we stick to the November 7 schedule, and I am sure everybody would concur with that.

Dr. SCHLENGER. Right.

Mr. STEINBERG. Dr. Houk, over the years since the Vietnam war, the prevalence of excess of suicides among Vietnam veterans has continued to be an issue; and there has been much comment in the media about various estimates of such a suicide rate. What were the findings from the VES mortality assessment with respect to suicides?

Dr. HOUK. In the VES mortality study, there was a 1.7 increase of suicide during the first 5 years after service in Vietnam. Beyond 5 years, that increase disappeared; and in fact there were fewer suicides in the Vietnam group than the other group.

I would like to comment if I may, Mr. Steinberg, and give a history of where these outrageous numbers have come from.

Mr. STEINBERG. I would like to ask you to do that very briefly if you would.

Dr. HOUK. Yes.

Mr. STEINBERG. But on the last point that you made, did not the totality of experience as you studied it for the first 5 years and for years after the first 5 years indicate no excess suicides?

Dr. HOUK. In totality, no excess suicides. It was limited to the first 5 years. The estimates of 50,000, 60,000, and 100,000 plus suicides do not bear any relationship to reality; the actual number is closer to 9,000 of the veterans who served in Vietnam.

We recently did a paper for the American Epidemiology Society, which I will submit for the record when it is published, which details all of these findings and examines all of the studies that are available on this issue.

Mr. STEINBERG. And the estimate with respect to that again was approximately 9,000 since Vietnam?

Dr. HOUK. 9,000 since Vietnam. There are 37 million males who were the age of 18 to 35 at some time during the Vietnam era. The total number of suicides in that 37 million people is 152,000. If the Vietnam veteran had 100,000 suicides, the 2.6 million Vietnam veterans would account for over two-thirds of the entire suicides in that age population.

Mr. STEINBERG. Would you submit for the record the summary that you alluded to earlier with respect to what you consider to be inaccurate data on suicides among Vietnam veterans and how that came to exist?

Dr. HOUK. Yes.

[Subsequently, Dr. Houk furnished the following information:]

SUICIDE AMONG VIETNAM VETERANS

The media have reported that suicides among Vietnam veterans range from 50,000 to over 100,000. In 1981, the figure of 50,000 was widely used. Then in 1986 and 1987, two books were published that suggested there were more than 60,000 suicides among Vietnam veterans. In October 1987, a lecturer in a history course on war appeared on a popular Sunday evening television program and stated that there were more than 100,000 suicides in Vietnam veterans. Mortality studies show that 9,000 is a better estimate.

Suicide among Vietnam veterans first emerged as a prominent national issue during the late 1970's. In October 1978, a Presidential Review Memorandum on Vietnam Era Veterans, which was provided to Congress, included the statement that Vietnam era veterans less than 34 years old had been found to have a suicide rate 23 percent higher than nonveterans. Subsequently, it was discovered that this reported excess of suicides was based on a study conducted in a Veterans' Administration (VA) Hospital in which hospitalized Vietnam era veterans were compared with older hospitalized patients. In early 1979, in response to a congressional inquiry, the statement regarding excess suicides was retracted by the Administrator of Veterans' Affairs. In a letter to the chairman of the House Committee on Veterans' Affairs, the Administrator wrote "There are no published statistics on rates of suicide among nonhospitalized Vietnam are veterans and hence no precise statement can be made regarding such rates relative to those for the general population matched for sex and age".

Evidently, this commentary on the suicide data was not widely disseminated. A VA psychiatrist repeated the report of excess suicides with an article that appeared in the Journal of the American Medical Association in August 1981. The President's Memorandum also continued to receive attention in the popular press and in veterans' magazines but with a significant difference. The increased risk for suicides was described as occurring just among the approximately 2.6 million veterans of the Vietnam war rather than among the more than 8 million veterans who served during the Vietnam era. Furthermore, the increased risk was described as occurring among Vietnam veterans of all ages.

The CDC Vietnam Experience Study Mortality Assessment showed that during the first 5 years after discharge deaths from suicide were 1.7 times more likely among Vietnam veterans than non-Vietnam veterans. After that initial postservice period, Vietnam veterans were no more likely to die from suicide than non-Vietnam veterans. In fact, after the 5-year postservice period, the rate of suicides is less in the Vietnam veterans group.

Of the several mortality studies of Vietnam veterans, only the CDC study and the Wisconsin Department of Health Vietnam Veterans Study provide suicide rates necessary to estimate the number of suicides among all Vietnam veterans. Using either study, the projected number is approximately 9,000 (95% CI=6,500-13,000) suicides expected among the 2.6 million veterans of the Vietnam war.

The proportion of deaths due to suicide in CDC's investigation (13%) is comparable with the proportions found in four State mortality studies (9%-16%)—Wisconsin, Massachusetts, New York, and West Virginia.

At any time during the Vietnam war, 37 million males in the United States were aged 18 through 35. Vital statistics show that the total number of suicides in this population of 37 million males through 1985 was slightly under 152,000. Of these 37 million males, 2.6 million served in Vietnam. If the reports in the press of up to 100,000 suicides were accurate, this would indicate that two-thirds of all the suicides that occurred in this population of 37 million men came from the 2.6 million who served in Vietnam. This is not supported by any factual information.

We have submitted to the committee a CDC presentation which was made at the 1988 meeting of the Society for Epidemiologic Research, June 15-17, 1988, in Vancouver, British Columbia, Canada, which was entitled "Estimating the Number of Suicides Among Vietnam Veterans".

Mr. STEINBERG. And also, I believe that that study that you made reference to discusses some of those occurrences.

Dr. HOUK. They are all included in what we are submitting to the record.

Mr. STEINBERG. That concludes our questions at this point. We are very grateful to you for traveling from North Carolina and Atlanta, respectively; and Dr. Hamada, we are particularly grateful to you for coming here from Honolulu. I am going to ask Dr. Hamada if he would remain at the table for a moment. We understand that Senator Matsunaga does plan to be here shortly. The other witnesses are excused.

We will call up the GAO, and, hopefully, we will have an opportunity for Senator Matsunaga to welcome you and ask you a question or two, Dr. Hamada.

Would the next panel please come forward? Mr. David Baine, Associate Director, Human Resources Division, accompanied by Mr. Bruce Layton, evaluator, Human Resources Division, and Mr. Gary Ulrich, evaluator, San Francisco Regional Office, all of the U.S. General Accounting Office.

Mr. Baine, I am going to depart momentarily from the schedule if that is agreeable to you, in addition to having Dr. Hamada join you, so that Senator Cranston or any other member who returns may be able to be here for your testimony.

Mr. BAINE. All right.

Mr. STEINBERG. I am going to ask you one or two questions, and then perhaps he will have returned from the roll call. Is that agreeable?

Mr. BAINE. Fine, sir.

Mr. STEINBERG. Do we understand you correctly, from your written testimony, that as to 7 of the 11 PTSD inpatient programs and 4 of the 9 long-term psychiatry programs that you surveyed, you found that although local program officials had clearly thought that by shortening lengths of stay so that they would receive greater funding through reimbursement under the RAM, actually they received less funding? Do we understand that correctly?

Mr. BAINE. That is correct, sir.

Mr. STEINBERG. And if we look at page 7 of your testimony, do we understand correctly—and you are the mathematical experts, so if we have miscalculated, please correct us—that the program that you looked at there ended up losing about $1,000 of the $8,522—I believe the exact figure is $978—that it had previously received for 120 days in its program?

Mr. **Baine**. That is right, and that is on a per-patient basis or per-discharge basis.

Mr. **Steinberg**. That is about a 15-percent or so reduction in this funding?

Mr. **Baine**. Yes, sir.

Mr. **Steinberg**. Do you have the data on the three drug and alcohol programs that you visited as to any actions taken to reduce lengths of stay and the effect under the RAM?

Mr. **Baine**. Under the three drug and alcohol programs?

Mr. **Steinberg**. Yes.

Mr. **Baine**. Where they reduced lengths of stay?

Mr. **Steinberg**. Yes.

Mr. **Baine**. And were penalized? Yes, we do have that, sir; and we will get it in just a second.

[Subsequently, Mr. Baine furnished the following information:]

One alcohol and drug program we visited reduced its predefined length of stay from 180 to 90 days. Before the change, the program earned $14,150 for a 180-day stay. After the 90 day reduction, the program earned $6,050 for each patient discharged—an $8,100 loss. The change gained the facility 90 days during which a new patient was treated, earning the program an additional $6,050. The net loss for the facility, then, was $2,050.

Mr. **Steinberg**. All right. If you wish to provide that for the record, that would be all right; but was there in sum or in all of those cases a similar experience where there was a reduction in length of stay and a reduction in funding, rather than an increase in funding?

Mr. **Baine**. Yes, sir. If I might, sir, this phenomenon seems to occur when there are predefined lengths of stay for a program that are outside the limits of the DRG in which the patients are categorized for that program. And as the length of stay is reduced, the credits provided to that program——

Mr. **Steinberg**. Credits meaning dollars, in essence, right?

Mr. **Baine**. Credits do mean dollars.

Mr. **Steinberg**. All right.

Mr. **Baine**. Or they are calculated in dollar terms. That does not mean that the individual programs lose *x* number of dollars, however. But as the credits are calculated, as the length of stay is reduced, each of those programs lost credit for each patient discharged.

Mr. **Steinberg**. Mr. Baine, I am going to ask you now to proceed to summarize your testimony in 5 minutes, if you would, please?

Mr. **Baine**. All right.

STATEMENT OF DAVID P. BAINE, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BRUCE LAYTON, EVALUATOR, HUMAN RESOURCES DIVISION; AND GARY ULRICH, EVALUATOR, SAN FRANCISCO REGIONAL OFFICE

Mr. **Baine**. We appreciate the opportunity to discuss the preliminary results of our work at several VA medical centers on inpatient programs providing treatment for veterans with post-traumatic stress disorders, alcohol and drug dependencies, and other long-term psychiatric disorders.

As you know, in fiscal year 1985, VA introduced a new budget allocation system called the resource allocation methodology. This methodology is intended to reward increased productivity and efficiency at VA centers. We visited 3 such medical centers to identify changes they had made in the programs in response to the new methodology and phoned officials at 11 other centers to discuss whether they had also made changes.

Officials had made changes in one or more of the programs at the centers we contacted and said that most of the changes were made in response to the incentives VA had incorporated into the methodology. These changes included reducing patients' lengths of stay and adding new program components, as well as staffing and administrative changes.

Center officials provided us their views on how the changes made in the programs affected the care provided to veterans. In general, changes made in response to the methodology were viewed as beneficial if they increased access to veterans and were perceived less favorably if they decreased such access.

However, VA to our knowledge had not conducted any local or national clinical evaluations to determine the effects of the changes made in the programs on the quality of care provided to veterans.

I would like to briefly discuss changes that were made to reduce programs lengths of stay, the type of change we found most frequently. Although some programs benefited under the methodology by discharging patients earlier than they were previously discharged, other programs—primarily those related to PTSD—were penalized rather than rewarded. Under the methodology, workload is measured through the use of diagnosis-related groups—a method used to classify patients with similar diagnoses and other characteristics.

Patients in each group are expected to have comparable costs of care based on similar lengths of stay. Medical centers earn a basic credit for each patient discharged under each DRG regardless of the patient's length of stay up to a limit.

For example, in fiscal year 1986, an alcohol and drug treatment program earned $1,550 for certain discharges within a 40-day limit. PTSD programs earned $1,772 for each patient discharged within a 45-day limit.

Programs which have predefined lengths of stay below the limit will benefit under the methodology, if they are able to discharge patients more rapidly and thereby treat additional patients within existing staffing and other resource constraints. For example, a predefined length of stay was reduced from 4 weeks to 2 weeks for an alcohol treatment program. This allowed the program to earn about $3,000 in the same period that it had earned $1,500 prior to the change.

However, according to program officials, the program's length of stay led to a change in the type of patient population served. Before the change, the program served patients with alcohol dependence problems that were complicated by the presence of other psychological difficulties.

Because officials felt these patients could not be treated within a 2-week period, new admissions to the program were restricted to patients with fewer complicating problems. Changes made to reduce lengths of stay can also penalize certain programs if the patients' lengths of stay always take much longer than the limit established for the DRG covering the patients.

For such patients, programs earned the basic rate for the DRG plus additional credits equivalent to $90 for each day of care over the established limit. For example, one PTSD program that we talked about earlier reduced its predefined length of stay from 120 days to 90 days and earned lower rather than higher credits under the methodology.

Before the change, the program earned about $8,500; after the 30-day reduction, the program earned about $5,800, or a $2,700 loss. The change gained the facility 30 days during which new patients were treated; however, the program earned $1,772 for the first 45 days of each new patient's stay.

We believe this occurred because the methodology is not adequate to measure the efforts of programs, such as PTSD programs, to increase productivity and efficiency.

Mr. STEINBERG. Mr. Baine, could I ask you to please try to summarize the end of your statement?

Mr. BAINE. Yes, sir. I just wanted to point out that VA has for some time been trying to analyze the relationship of the DRG system and its resource allocation methodology to its psychiatry programs. In addition, it has made some changes in the way it will allocate funds in fiscal year 1989; and it is not yet clear to us exactly how those changes are going to affect programs such as PTSD. Thank you, sir.

Senator MATSUNAGA [presiding]. Thank you very much, Mr. Baine.

[The prepared statement of Mr. Baine appears on p. 247.]

OPENING STATEMENT OF SENATOR MATSUNAGA

Senator MATSUNAGA. While it may seem a little unusual—although it is not unusual for a Senator to have to be several places at the same time—and I regret very much I was unable to be here to greet my good friend from Hawaii who testified with the earlier group.

With your kind permission, members of the panel, I would like now to revert back to a member of the first panel, who came here upon my invitation. So, I would like to take this opportunity, Dr. Hamada, to welcome you to this hearing before the Committee on Veterans' Affairs and express my deep appreciation for your responding affirmatively upon such short notice.

Without objection, I have a statement that I would like to insert into the record.

Now, I would like to ask you this question: How do cultural factors impact on the identification, epidemiology, treatment, and prevention of PTSD in minority Vietnam combat veterans?

[The prepared statement of Senator Matsunaga appears on p. 124.]

Dr. HAMADA. Senator Matsunaga, first of all, I would like to thank you for inviting me. It was a privilege and a pleasure to be here. Now, to get to your question.

I believe that cultural factors have a significant impact on each of those areas that you have mentioned. The identification and the epidemiology of PTSD among minority veterans are impacted in a similar way by cultural factors.

Cultural factors will influence the manifestations of symptoms in veterans who are suffering from post-traumatic stress disorder and, therefore, have a bearing on the primary objective of epidemiological research, which is to count the number of cases of disorder.

For example, among Asian-Americans, many Asian-Americans will manifest stress in somatic symptoms, that is, in bodily or physical ailments rather than in the more typically accepted psychosocial areas that are manifested in White veterans.

It is important to consider cultural factors in the epidemiology of PTSD in order to obtain the most accurate data. If the epidemiology studies are carried out on identified cases, it is well established that minority veterans underutilize services. So, this kind of study would not yield a valid estimate.

The kind of methodology used by both the VES study and by the national Vietnam veterans readjustment study would be more suitable for use in studying minority veterans.

Regarding the treatment, culturally sensitive treatment is critical in treating PTSD in ethnic minority veterans. For example, Asian-American veterans experience a great deal of stigma and shame associated with admitting to personal problems or anything that smacks of "mental illness."

So, it has been found in research that Asian-American clients are considered the most repressed clients and difficult to work with. It is well established that minority clients drop out of treatment early, sometimes after just one session; and we believe that this is due to cultural factors and incongruence in expectations of the counselors and the clients.

Counselors expect clients to be psychologically minded and to discuss freely intimate details of their life; and this just doesn't fit with a number of minority groups.

Senator MATSUNAGA. Yes.

Dr. HAMADA. On the client side, many minority clients will expect direction by counselors and discussion of concrete details, and the more traditional counselors will not see this as their primary goal in therapy.

I think in the area of prevention, it is important to study cultural factors because many ethnic minorities utilize alternate health systems, rather than the formal health system established; and doubtless, these alternate health systems are effective.

For example, there has been some research by Dr. John Wilson at Cleveland State with the American Indians. Certain nations of the American Indians being warrior nations have developed rituals and ceremonies which they use to send warriors off to battle and which they also use to welcome warriors back into their society. Although I am not aware of any firm evidence of the effect of these ceremonies, it certainly is feasible that they may already have a methodology which can contribute to preventing PTSD.

So, I think it is important in studying the prevention of PTSD to look to cultural factors for clues as to successful prevention.

Senator MATSUNAGA. Thank you very much, Dr. Hamada. Now, as you know, I recently introduced legislation to require the VA to conduct a study of the prevalence and effect of PTSD and other psychological problems suffered by Asian-Americans and Pacific Islander American Vietnam veterans. The committee has approved my bill and, as a matter of fact, expanded the scope of the study to include native Americans. Are you in support of this legislation which I introduced?

Dr. HAMADA. I am wholeheartedly in support of it, Senator; and I congratulate you and the members of the committee on your insight into the problem.

Senator MATSUNAGA. Thank you very much. I am glad I invited you to appear before this committee. [Laughter.]

Senator MATSUNAGA. Mr. Chairman, I have to go to another markup session. Thank you, and I apologize to you, for breaking in.

Mr. BAINE. That is fine, sir.

Mr. STEINBERG. Thank you. Dr. Hamada, you may be excused, and thank you.

Dr. HAMADA. Thank you.

Chairman CRANSTON. I would like to recognize Senator Simpson, former chairman of this committee and a long-time valued member of it, for a brief statement he wishes to make.

OPENING STATEMENT OF SENATOR SIMPSON

Senator SIMPSON. Mr. Chairman, thank you very much. After the debate the other day, I wandered up to the committee room, and I thought they had closed the door, trying to hide from me where they were; but I found them. I know where you are now.

Chairman CRANSTON. We thought you couldn't find us. [Laughter.]

Senator SIMPSON. Anyway, that was rather spirited. Thank you, and I really do not have a lengthy statement; but this is a serious issue. It was a serious issue when I was chairman of the committee for 6 years and worked with Al Cranston when he was the ranking member.

This was an issue that I spent a lot of time on and became convinced of the need for vet centers and some of the special care because I was a veteran of the tail end of the Army of Occupation and spent a couple of years in Germany. I guess, like many veterans of that era, I did not understand the Vietnam war and the very special damage to the psyche that it caused; and I am convinced that that indeed did take place.

This condition of post-traumatic stress disorder and its appropriate treatment is indeed an issue with which we are concerned; and we have put a lot of resources in it already, both in readjustment counseling and in medical and psychiatric programs. And we will do more; I am sure of that.

There is much we need to know about the debilitating aftereffect of war, and it is appropriate that this committee consider what is being done and what needs to be done. That is certainly what the Committee on Veterans' Affairs has done under the very capable leadership of Al Cranston, with Frank Murkowski as the ranking member.

Here is a condition that does not appear to be one that affects all, or even substantially all, veterans. There are 28 million of us, and I don't know what figures are ranging here, but perhaps as high as several hundred thousand and as low as, well, I am not positive.

Statistics lead us nowhere, but at least it is a condition about which we are concerned because it is one caused by combat conditions. I guess in World War I, we called that shellshock. In World War II, we called it battle fatigue. And as the aftereffects of this war, we have now PTSD.

So, I look forward to reviewing the testimony to be offered. I do note that Bob Meredith, the team leader of the vet center in Wyoming is part of the panel and will take part in this hearing. He is from Cheyenne and a very able man; we are very pleased to have him there, recognizing what I say about the problem of the disorder itself.

So, I look forward to the opportunity to hear from him. As always, I have the Environment and Public Works Committee and then we have some floor duty. Mr. Chairman, if I don't return, I would appreciate your extending those questions to Mr. Meredith; and I thank you and look forward very much to working with you.

I will try to get back to address those questions to Bob personally. He has done a great job in Wyoming. We want to see that our job is done, and we have never failed that test in this committee ever, whether you have been chairman or I have been chairman or Frank has been chairman. Thank you, Mr. Chairman.

Chairman **Cranston**. Thank you very much, Alan. I assure you that your questions will be passed on. I regret that you have to leave, but I understand.

Mr. Baine, your findings suggest that the RAM in these instances is a strange way to establish incentives for greater productivity and efficiency—when the reward only appears to be there, but in reality the programs are penalized for making decisions the policymakers are apparently promoting? Is that correct?

Mr. **Baine**. Essentially, that is correct, sir. If I might correct an answer I gave to Mr. Steinberg before you came back with regard to some drug and alcohol programs, I believe under the methodology, two of the programs were rewarded as a result of changes made in those programs, and one was penalized. I believe I said earlier that all three were penalized.

Mr. **Steinberg**. Thank you.

Mr. **Baine**. Essentially, Mr. Chairman, you are correct. I believe the VA is assessing the applicability of the methodology to a range of psychiatric services. Exactly what the VA is going to do as a result of that assessment, we are not quite sure; but I believe they have it under advisement.

I noticed in Dr. Gronvall's prepared statement that, with regard to PTSD, they are looking at an option to remove the long-term inpatient PTSD program from the DRG in which it is currently located.

Chairman **Cranston**. Thank you very much. That concludes our questions to you, and I thank each of you for your help on this. I am sorry that I had to be absent for part of your presentation.

Mr. **Baine**. You are most welcome, sir.

Chairman **Cranston**. I ask our next panel of witnesses now to come forward. It consists of Dr. Matthew Friedman, Chairman, Veterans' Administration Advisory Committee on PTSD, VA Medical Center, White River Junction, VT; Dr. Patrick Boudewyns, chief of psychology, VA Medical Center, Augusta, GA; Ms. Joan Furey, R.N., associate chief, Nursing Service, Nursing Home Care Unit, VA Medical Center, Bay Pines, FL; and Mr. Fred Gusman, MSW, Director, PTSD Treatment Program, VA Medical Center, Palo Alto (Menlo Park Division), CA.

I appreciate all of your coming considerable distances to be with us this morning. Mr. Gusman, as your Senator, I want particularly to welcome you to this session. I know of your excellent and highly innovative work.

Before we get started, I would like to thank you and the other three panelists and all the other dedicated, hard working individuals who have served with you on the Special Committee on PTSD for the truly valuable and far-reaching work you have done. Each of the four annual reports contains a wealth of information and ideas, and I look forward to the fifth annual report.

As you may be aware, the committee recently favorably reported a bill, S. 2011, which would provide in part for the extension of the reporting requirements of the special committee, requiring annual reports for the next 3 years. Again, I thank you for your dedication and for your efforts.

Mr. **Gusman**. Thank you, Mr. Chairman.

Chairman **Cranston**. Please proceed, Dr. Friedman.

STATEMENT OF DR. MATTHEW J. FRIEDMAN, CHAIRMAN, VETERANS' ADMINISTRATION CHIEF MEDICAL DIRECTOR'S SPECIAL COMMITTEE ON PTSD, VA MEDICAL CENTER, WHITE RIVER JUNCTION, VT

Dr. **Friedman**. Mr. Chairman and distinguished members of the committee, it is an honor and a privilege to testify before the Senate Veterans' Affairs Committee in my capacity as Chairman of the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder.

Your continued interest and concern about the psychological consequences of combat is absolutely essential if the Veterans' Administration can be expected to meet its historic obligation and provide treatment for those men and women whose lives have been devastated while defending their country.

The Veterans' Administration is the largest health-care system in the world. It provides treatment for the whole spectrum of medical, surgical, and psychiatric problems. Given the diversity of medical problems facing VA clinicians and given growing competition for limited VA resources, it is becoming more and more difficult to set priorities for resource allocation. From time to time, we all need to be reminded that the primary mission of the Veterans' Administration is to bind up the wounds of war.

I do not mean to imply that heart disease, AIDS, diabetes, and schizophrenia are not very serious disorders that can become completely disabling. What I do mean is that, if we must make hard choices because of scarce dollars, then the priorities of the Veterans' Administration must emphasize first and foremost those conditions that have resulted directly from exposure to combat.

Therefore, it is my belief and the belief of all my colleagues on the special committee that post-traumatic stress disorder must be at the very top of the VA's priority list. In my opinion, this has not been the case.

Where there has certainly been progress in the capacity of VA professionals to diagnose and treat PTSD, this progress has been hampered because there has been a limitation on the amount of resources devoted to meet this objective.

In my allotted 5 minutes, I cannot possibly summarize the 400 pages of reports submitted by the special committee to Congress since 1984. My written testimony outlines these four annual reports and briefly discusses the various VA programs for treating PTSD and what progress has been made in that regard since 1984.

Specifically, I have outlined the special committee's extensive review of the entire spectrum of VA programs devoted to PTSD, including the National Center for PTSD, VA Medical Center Inpatient and Outpatient Clinical Programs, the Vet Center Program, specialized inpatient PTSD units, PTSD treatment teams, VA research on PTSD, educational programs on PTSD, veterans' benefits issues with respect to PTSD; and I close, in my written testimony, with a description of the special committee's work in progress and plans for the future.

I will be happy to elaborate on those details during the question and answer phase of my testimony.

At this time, however, I want to reemphasize that your concern about PTSD is crucial. If you agree with me that combat-related PTSD is what the VA's mission is all about, and if you agree with me that combat-related PTSD must be one of the top priorities for the Veterans' Administration, then your explicit concern about PTSD will help VA officials set such a priority as they seek to provide the best health care for our Nation's veterans. Thank you.

Chairman CRANSTON. Thank you very much. I will be exploring with Dr. Gronvall and the VA what is in your reports. We will be endeavoring to learn more about them and get the VA's informed views on those subjects. Dr. Boudewyns?

[The prepared statement of Dr. Friedman appears on p. 257.]

STATEMENT OF DR. PATRICK A. BOUDEWYNS, CHIEF, PSYCHOLOGY SERVICE, VA MEDICAL CENTER, AUGUSTA, GA

Dr. BOUDEWYNS. Mr. Chairman, I am Pat Boudewyns, Chief of the Psychology Service at the VA Medical Center in Augusta, GA; and I am also a principal investigator in the research service of the VA with a grant to study PTSD.

I am further a member of the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder and was chairman of a task force of those members from the CMD special committee assigned to conduct a site visit to the National Center for Stress Recovery [CSR] at the VA Medical Center in Cleveland at the Brecksville Division. This is a report on that visit which was carried out on November 16–18, 1987.

The committee's objective was to evaluate the Center for Stress Recovery in accordance with the mandate of the law which created the center. This law, Public Law 98–528, mandates that the CSR—

> Carry out and promote the training of health care and related personnel in and research into the causes and diagnosis of PTSD in the treatment of veterans with PTSD, and to serve as a resource center for and promote and seek to coordinate the exchange of information regarding all research and training activities carried out by the Veterans' Administration and by other Federal and non-Federal entities with respect to post-traumatic stress disorder.

In my written testimony, I have a much more complete report; but let me go directly to our findings.

Based on material supplied by the VA central office, the Brecksville VAMC, the Center for Stress Recovery, and on meeting with many key personnel seen at Brecksville during the site visit, the task force came to the following conclusions and recommendations:

One, the Center for Stress Recovery has never functioned as a "national center" in any of the areas of concern, including research, education, patient care, and communication and networking.

Two, although some preliminary efforts at national involvement have been made by some CSR staff, it is clear that the academic-scientific environment at Brecksville is not conducive to the development of productive national program in PTSD.

Three, the present treatment approach at the CSR is too highly structured and rigid to serve even the local needs.

These were our recommendations:

One, that the special committee should advise the Chief Medical Director to immediately remove the designation "national" from the title of Center for Stress Recovery.

Two, that the Center for Stress Recovery not be allowed to implement the lengthy, detailed, and expensive educational package it wants to disseminate in regard to the model at this time.

Three, that the special committee request that a national center or consortium for PTSD that can truly meet congressional mandates be made operational.

Four, if such a national center is established, some form of monitoring mechanism at the central office level should be used to assure compliance with established guidelines.

Five, if such a center is established, it should be done via a request for proposal, a procedure commonly used for other national research, training, and patient-care programs that are established by national bureaucracies.

Finally, the treatment program at the Center for Stress Recovery should be less rigid and include the use of other more common treatment methodologies, such as vocational counseling, alcohol and drug abuse treatment, where appropriate, if it is to serve local needs.

Mr. Chairman, in closing I would like to thank the committee for their interest and support of our work on PTSD; and I will be glad to answer any questions.

Chairman CRANSTON. Thank you very much. Ms. Furrey, I understand you have no opening statement, so we will go to Mr. Gusman.

[The prepared statement of Dr. Boudewyns appears on p. 309.]

STATEMENT OF FRED GUSMAN, DIRECTOR, SPECIALIZED TREATMENT CENTER FOR PTSD, VA MEDICAL CENTER, PALO ALTO (MENLO PARK DIVISION), CA

Mr. GUSMAN. As a member of the CMD's committee, I have been charged by the committee to monitor and collect data on the inpatient PTSD treatment programs and treatment teams. I would like to submit for your attention some of the recent data that we have collected on the inpatient treatment programs.

Ten of the initial inpatient programs for PTSD were actually begun prior to 1984, Menlo Park being the first program, beginning in January 1978. These 10 programs were not by any means funded through central office funding, as far as the committee has been able to identify, or by regional funds. All these were self-startup programs where the medical center or particular individuals at that medical center or public pressure forced the medical center to address an unmet need.

After the Subcommittee on Hospital and Health Care held its hearings on March 29, 1984, VA central office allocated 70 FTEE and salary dollars averaging approximately at $34,611.50 per FTEE. The majority of this FTEE went to the Center for Stress Recovery, approximately 30.

There were other FTEE that were allocated for two medical centers for startup programs and a portion of FTEE was utilized to augment existing inpatient programs.

As I have already submitted my written testimony, I would like to make some overview comments on what we have found.

Right now, the committee feels that we could classify the current inpatient programs for PTSD. I do not use the term "specialized" because I believe that the committee feels that that term identifies a center, or would identify a center, of excellence.

We define these programs as inpatient treatment programs for PTSD under the following three categories: first, problematic of uneven quality; second, adequate standards of care; and third recognized centers of excellence, the third category being in the minority.

There have been many problems that these programs have faced over the years. Some of these problems relate to the fact that PTSD—as we have made many side visits across the country and to these programs—has still not been perceived as a priority by the local medical centers. There are exceptions, though.

Of the 15 and proposed 20 new programs, as I understand has been approved, possibly a quarter of those have the support of the medical center and the chiefs of services.

With the existing programs, we have numerous problems. We have waiting lists that can cause a patient to wait as long as 6 months to a year. We have programs that, either because of their inability to access resources at their local facilities; or because of their intention to isolate themselves, do not utilize the support possible or available to them.

More recently, the committee has heard from these programs of their concern about beneficiary travel. As had been said earlier by GAO, many of these programs exist in areas that are not necessarily adjacent to many of the veterans who are in need. Therefore, veterans have to travel hundreds, and in some cases thousands, of miles.

The committee questions whether or not the PTSD programs as they exist today serve the immediate acute needs of the PTSD veteran. In our next report, we plan to investigate this notion further.

Let me move to the PTSD treatment teams themselves.

Chairman CRANSTON. Yes, and if you could summarize pretty rapidly because your time is up.

Mr. GUSMAN. The PTSD treatment teams, which are new and were just put into action in January 1987, have also had a somewhat floundering experience. My suggestion to you, Senator, is we need to really set PTSD treatment teams as a priority; we need to have adequate and appropriate funding and FTEE, and the support of mental health and behavioral sciences experts who have the ability to provide this. Thank you.

Chairman CRANSTON. Thank you very much.

[The prepared statement of Mr. Gusman appears on p. 319.]

Chairman CRANSTON. I am going to start with some questions for you, Dr. Friedman, and please feel free to direct the question to others if you wish to do so. The other members of the panel should feel free to comment if they have anything to add to or subtract from what Dr. Friedman says.

First, what has been the VA's response to the special committee's recommendations in both its 1985 and 1986 annual reports that additional resources should either be allocated or reassigned for the diagnosis and treatment of PTSD?

Dr. FRIEDMAN. I think that there have been perhaps two tangible examples of some response to that recommendation, the most tangible one being the initiation of the 15 PTSD treatment teams that Fred Gusman just mentioned. However, we have had some real concerns about how these teams were selected and how they have been monitored; and we are particularly concerned because the concept of the PTSD treatment team was actually developed by the special committee and was enunciated in the first recommendation that the special committee ever made.

We made it in our first annual report, which was submitted in February 1985. The thinking behind the PTSD team was that, there are only 172 VA hospitals although, veterans with post-traumatic stress disorder are disbursed throughout the country.

It was our feeling that the primary resource allocation ought to be to improve the capacity of every single VA facility across the country to treat the veterans with PTSD. We felt that this was much more important than bolstering a dozen or so special inpatient units across the country.

That is not to say that we don't support the important role of special units; but we felt that an across-the-board improvement in resource allocation was the No. 1 priority. We believed that this could be achieved by establishing PTSD teams at every VA medical center. It was our understanding that this recommendation would be implemented.

However, as of now, only 15 teams have been implemented, and we have some real concerns about the fact that no more are currently planned. Furthermore, the ones that are out there have had a fairly uneven course.

Chairman CRANSTON. Thank you very much. Given your experience and the data collected by the committee, for instance, that 35.8 percent of Vietnam combat veterans seen in mental health outpatient programs are diagnosed as having PTSD, what is your view of RTI's estimate of 15 percent as the current proportion of Vietnam theater veterans with PTSD?

Dr. FRIEDMAN. That is a very difficult question to answer at this time. Certainly one of the things that the special committee hopes to do, if we are extended in time, is to mesh our clinical utilization data with the epidemiological data that you heard about this morning.

But it is important to understand right now that we are talking about apples and oranges. The patients who come to the VA hospital for treatment, to the best of our knowledge, are in no way a representative sample of the veteran population across the country.

They tend to be people who are perhaps particularly chronic in terms of their symptoms. They tend to be people who are economically disadvantaged. They don't have the kind of insurance coverage so that they could seek treatment at other places.

So, my own feeling is that 15 percent is probably a low estimate.

Chairman CRANSTON. That would be what?

Dr. FRIEDMAN. A low estimate of the percentage of patients seeking VA care who have PTSD. If the capacity of the Veterans' Administration to identify and treat PTSD were improved and if the VA's expertise with PTSD were recognized throughout the veteran community, the percentage probably would be much higher. Again, we won't know how well the VA is meeting current needs until we can mesh our data with the RTI data.

Chairman CRANSTON. As you know, in S. 2011, the committee has reported favorably a provision which would extend the reporting requirements of your committee thereby giving you the time for study of all this. We hope you will keep in touch with us as new facts emerge.

Dr. FRIEDMAN. Thank you.

Chairman CRANSTON. One of the issues raised by the committee in several of its annual reports and again by your testimony is the existence of significant variability in the specialized inpatient, generalized inpatient and outpatient and vet center care devoted to PTSD across the VA system.

Would you briefly describe what you see as the problems associated with the existence of this variability?

Dr. FRIEDMAN. There are several problems, and I am sure my colleagues at the table will want to chip in after I have said my piece. The first problem is that a medical care system is supposed to have clinical skills—clinical capacity and clinical excellence—and there ought to be at least minimal skills across the board.

That doesn't seem to be the case. So, on the one hand, veterans who are currently seeking care are getting uneven care, depending on what particular hospital or vet center or what other VA facility happens to be in their geographical part of the country.

Second, when one has this kind of variability, it tends to undermine the credibility of the Veterans' Administration as a clinical system that is capable of diagnosing and treating PTSD. So, I think what we are going to find, and we have already heard about it earlier this morning, is that many veterans with post-traumatic stress disorder have never come to the VA for treatment.

And I think that part of that is because of the fact that the VA has some serious credibility problems in its capacity to recognize and treat this disorder, particularly in certain parts of the country.

Chairman **CRANSTON**. What, in your view, are the benefits and drawbacks of having program guidelines?

Mr. **GUSMAN**. Maybe I can answer that since I have been tracking this and have been in this business since 1978, running a program. We feel, as a committee, that after doing numerous site visits that clearly this unevenness breeds inadequate care; and that with guidelines, at least we can probably have identified some basic standards of care.

Right now, there is such a variance that, if a fellow was to go one place, he would get one type of treatment based on what the philosophy was of that particular clinician, or if that clinician is paying attention to the DRG, or whatever, that will dictate the treatment.

So, if there were guidelines, I would feel that at least the veteran would have a fair chance, an opportunity to get adequate care. There are so many variables right now that influence treatment planning and treatment programming that it would take us days to share all that with you.

But I can say guidelines and the ability to support those guidelines would be extremely important. Without that support—without some form of regulations, some sort of accountability—they would be totally useless.

Dr. **FRIEDMAN**. I think what has been missing has been oversight and accountability. Oversight on the part of the Veterans' Administration, both central office and the seven regional offices, in order to be able to look at these various programs in their districts or regions, to see how well they are doing. You need minimal standards in order to do that.

On the other side of that coin, of course, is accountability on the part of the various facilities to be able to demonstrate that they indeed have the clinical skills and the wherewithal and the programmatic capacity to do what they are supposed to be doing in terms of the VA's mission.

Chairman **CRANSTON**. Dr. Friedman, with regard to establishing evaluation criteria for the specialized inpatient units, I note that in your testimony you state that the committee in its 1986 report recommended that such criteria be established. Although the CMD agreed in concept with that recommendation, no criteria have actually been developed. Is that correct?

Dr. **FRIEDMAN**. That is correct. We basically provided an outline in our 1986 report around which such guidelines could be made and programs could be evaluated. We are talking about February 1986 when we submitted that report.

I understand that a program guide for inpatient units is in process, but, you know, it has been a long time since 1986.

Mr. GUSMAN. I might add that the standards of care for this guideline would hopefully benefit the program to be seen as a medical center priority. I feel that it is important that we underline this. The guidelines would be useful if the medical center responded to those guidelines, making it a priority because many of these programs are entities unto themselves as they operate.

Chairman CRANSTON. Along these same lines, I note that in 1986 the committee recommended and the CMD agreed that periodic site visits to conduct evaluations of the VA's 13 existing specialized PTSD units should occur. To date, have any such visits occurred?

Dr. FRIEDMAN. Certainly not as part of a periodic review. I do note that there have been site visits that have been conducted in response to problems that had flared up; but as an institutionalized systematic, periodic review, I am not aware that that has been put in place.

I should add that the special committee in the last year has made a new initiative. In addition to working with the VA officials in central office here in Washington, we have established contact with the seven regional directors. In our opinion, it is essential that much of the monitoring and oversight be conducted at the regional level. We think that that is probably more manageable.

It was for that reason that the huge data package that was presented in our third annual report has been reformatted and reanalyzed so that we develop data packages for each of the seven regional directors. It is our hope that periodic review of not just the special units, but of the hospitals and of the vet centers and of the treatment teams, be part of the regional periodic review process if it is too unwieldly to manage from central office.

Chairman CRANSTON. Would you or Fred Gusman comment on the sufficiency of geographic distribution of the specialized inpatient units, especially in terms of the lack of correspondence between the location and the greatest population of veterans?

Dr. FRIEDMAN. They are insufficient. It is clear that most of the special units are either on the east coast, in the Great Lakes area, or on the west coast. There is Topeka, KS and a recently activated unit in Little Rock in the midsection of the country, and that is all there is.

Certainly, the two areas of the country where most Vietnam vets live, which is southern California and Texas, do not have a special unit. I think, because of what Fred Gusman said earlier, that there hasn't been a central direction for the establishment of these units.

These units have essentially developed de novo out of local initiative; and because of that, what you have really is a distribution of where the interest in PTSD is across the country, rather than where the need should be.

Mr. GUSMAN. I would like to add to that. The committee has been looking at the possibility that we probably should identify what we would term "regional programs," therefore at least providing in each region one program that can provide access to avoid waiting lists.

We would encourage and support programs to be initiated but also encourage that those programs have technical assistance provided by people who have the expertise in developing those types of programs because what we would not like to see, I believe, is new programs starting and going through the same wheel process that many of us have gone through and then eventually ending up closing.

Chairman **Cranston**. Do any of you have any comments on the testimony from the GAO, which you heard earlier today, regarding changes made by some PTSD treatment programs in response to the RAM?

Mr. **Gusman**. I can speak about the inpatient ones real quick; although the programs wish to go unidentified, it is evident that they have changed their program structure and not created a burden for the medical center.

Dr. **Boudewyns**. I would point out that I think the figure that was used by the GAO was that PTSD, for the first 45 days, receives $1,700. That has been increased as of this fiscal year, and I think it is up closer to $2,300; I don't know the exact amount.

At Augusta, we also make our money on outliers; so we have to have a long program. We couldn't treat people within the 2 or 3 week time period. So, we have to go beyond the 45-day period in order to make enough money to support even the staff that we have.

Dr. **Friedman**. I think it is important to state at the outset that most PTSD is not treated in special units. I think there is fixation out there, perhaps because of the adjective "special"—but the special units are really psychiatric intensive care units where patients who have been unable to benefit from treatment in vet centers, in VA hospitals in mental hygiene clinics, or in VA psychiatric inpatient units are referred for intensive treatment. A special unit is really the last port of call, clinically speaking.

So, by definition, the patients who should be hospitalized in these special units are the most refractory, the most intensely disabled by their post-traumatic stress disorder. You have that demand; that is the clinical demand.

The special committee is convinced that the special demand is there and that special units have their role to play in the spectrum of treatment alternatives for people with PTSD; but then you have a reimbursement system that doesn't recognize the intensity of clinical treatment that is required in terms of staffing, nor the duration of treatment that is required.

The bottom line is that fiscal considerations, which are certainly not inconsiderable, are dictating practice patterns. In effect we have a reimbursement system that is neither realistic nor equitable in terms of what it takes to provide intensive treatment. Consequently, in order to do what is programmatically necessary, hospitals are going to generally lose money. Given the fiscal crunch that you all know about, decisions are made not to lose money rather than to provide the kind of treatment programs that are necessary. It is a very bad squeeze.

So, what many programs do is to run very lean in terms of staffing, so they can pick up their dollars on their outliers. Well, that is in essence a contradiction in terms: To have a treatment-intensive program that has to run on lean staff because of an unrealistic reimbursement formula.

Chairman **Cranston**. Dr. Boudewyns, we welcome you back as a witness. Could you tell us with regard to reestablishing a successful national center of excellence for the treatment of PTSD what is your estimate of a reasonable annual budget?

Dr. **Boudewyns**. I think that we have worked up some figures on this and that Dr. Friedman has submitted recently. He has them right here, and perhaps we should let him do that.

Dr. **Friedman**. I haven't submitted them; we have been working on them very recently. Before I give you a dollar figure, I would like to tell the committee what we feel a national center for PTSD ought to be because we think that this is a major opportunity for the Veterans' Administration to have a leadership role, not just nationally but globally speaking, if it is willing to seize the opportunity and lead the country in terms of treating PTSD.

We feel that a national center for post-traumatic stress disorder should perform research and educational functions, as well as clinical activities. The clinical activities should be to support the research and educational functions, not the other way around. The national center for post-traumatic stress disorder should control its own intramural, educational, and training budget and this budget should be completely exempt from RAM constraints.

We think that only the patient care, nonresearch activities at a national center should be subject to the RAM; but none of the research or educational activities should be. We feel that a national center need not be located at one particular site, but could be a consortium of facilities.

A key to a national center for post-traumatic stress disorder that was completely lacking at the Cleveland/Brecksville facility was a very strong medical school affiliation in which the activities of the national center are well integrated with the academic interests of the affiliated Department of Psychiatry.

We feel that the director of the national center should report directly to the Chief Medical Director, and we feel that because the national center, as we see it, will have both educational and research activities as well as the clinical activities.

We think a national center should foster multidisciplinary activities in research and education and training and that it should assume a leadership role in promoting educational activities with respect to PTSD and that a national center should serve as a clearinghouse to disseminate information on national research and clinical activities on PTSD.

We think a national center should have access to a special inpatient unit; but as I said before, that should be to support the educational and research activities.

Now, having said that, the committee has made an estimate of what we think it would take to launch a national center that would truly be a national center for post-traumatic stress disorder. We feel that a little more than $7 million would be required in order to do this. I can break that down if you wish.

Chairman **Cranston**. If you would for the record, please?

[Subsequently, Dr. Friedman furnished the information which appears on p. 295.]

Chairman **Cranston**. How much was devoted annually to the center at Brecksville?

Dr. **Friedman**. $1.4 million.

Chairman **Cranston**. Thank you. I want to continue with you for a moment.

Mr. **Steinberg**. Dr. Friedman, when you give us the budget data, will you please indicate what is recurring expense and what is nonrecurring expense?

Dr. **Friedman**. Yes.

Mr. **Steinberg**. Thank you.

Chairman **Cranston**. Dr. Friedman, on pages 29 through 40 of the RTI's submission for today's hearing, they present a comparison of the NVVRS for the CDC Vietnam experience study. After you have had an opportunity to review that comparison and the methodology used by each of the two studies, would you please provide your comments on the two studies to the committee in writing, and do that by July 22?

Dr. **Friedman**. What page was that?

Chairman **Cranston**. Pages 29 through 40. I don't want you to reply now. I would like to have that in writing by July 22. If you would also please comment for the record by the same date on the effectiveness of the Outward Bound Program in treating veterans suffering from PTSD?

[Subsequently, Dr. Friedman furnished the information which appears on p. 297.]

Chairman **Cranston**. I would like to turn to you now, Dr. Boudewyns. The recommendations made by the special committee with regard to the establishment of a national center for PTSD seemed to have a great deal of merit. Later today, I will be asking Dr. Gronvall to comment on those recommendations in some detail.

With regard to the location of the national center at either one site or at a multiple site consortium, would you or anyone else on the panel comment on the benefits or drawbacks of each configuration?

Dr. **Boudewyns**. Configuration of a single site or multiple sites?

Chairman **Cranston**. Yes.

Dr. **Boudewyns**. Starting with the multiple center, you do have the advantage of going where the expertise is. If you were to select several sites, then you could pick people who have expertise in research or in clinical skills at different sites and combine them, rather than picking a center somewhere and saying, OK, that is it.

That was the problem at Brecksville. It was put there without much regard for whether there was any research expertise, whether the medical school that was there would support the program, or whether there was the clinical expertise or motivation to carry out the program.

It was set there, and then the idea was to bring people in. If you don't have an environment in which these experts want to operate, then they won't come; and that is what happened there.

So, that would be the advantage of a multiple site.

Obviously, a single site would have the advantage of not having to travel as much in order to communicate.

Mr. **Gusman**. I would like to add to that. One of the positive factors of having a multiple site is that a multiple site then possibly could be under more scrutiny, could have particular standards that are set and identified. And should one of those components fail to meet its responsibility, then I would feel that it would be easier for the VA to remove whatever funding or whatever responsibility it had to a site that was capable of doing that.

When you have single site, that becomes extremely difficult, I believe, because there are a number of variables involved, not the least of which I would mention is politics.

Chairman **Cranston**. One of the recommendations from the site visit—and I am still addressing you, Dr. Boudewyns—is that the current Center for Stress Recovery not be allowed to implement the lengthy, detailed educational package that it wants to disseminate. What is the objection to that educational package?

Dr. **Boudewyns**. The problem we felt was that that particular center had developed a very esoteric, circumscribed treatment program that had not withstood research evaluation and that they had implemented that program by themselves, without input from other experts around the country.

So, we didn't really have any information as to whether or not it was effective. And the educational program proposed by the center would be one which would communicate and educate people in the utilization of this rather unused technique which we felt had not withstood the scrutiny of research evaluation. That was the main objection.

Chairman **Cranston**. What is the current status of the educational project?

Dr. **Boudewyns**. At the center? As far as I know, it has not been implemented.

Chairman **Cranston**. In terms of reestablishing a national center, would you explain why you believe it is important that the choice of location be made via a request for proposal procedure?

Dr. **Boudewyns**. We feel that that would be the best way to attract experts in the field. It is the most common method that is used for determining support for research grants and for contracts. It is one in which we have a lot of experience, and we know it works; and I think that it would reduce the probability of ending up with another situation like Brecksville.

Chairman **Cranston**. I am now going to turn to you, Ms. Furey. The time has come to break your silence at the witness table. We heard earlier this morning that 9 percent of women veterans who served in Vietnam are currently suffering from PTSD; and yet from the reports we receive, it appears that women veterans are not seeking care from the VA in any significant numbers.

Do you have any view on why women veterans are not seeking health care from the VA?

TESTIMONY OF JOAN FUREY, ASSOCIATE CHIEF, NURSING SERVICE, NURSING HOME CARE UNIT, VA MEDICAL CENTER, BAY PINES, FL

Ms. **Furey**. Yes, sir. As you may be aware, this is the first time that women veterans have been involved in any national study or any study of any scope to give us some real concrete data on the experience of women veterans.

There have been some smaller, less comprehensive studies that also indicate that women are experiencing a degree of PTSD and other psychological distress symptoms. Their actual utilization rates of VA resources is an area we are interested in; the committee has made that a goal for its coming report, to take a look at the data from both the RTI study and a preliminary survey that we did in 1986 on the utilization rates and patterns of all veterans.

Our preliminary data indicated that 3 percent of the veterans seeking mental health services from the VA were women. Among those women who had a diagnosis of PTSD, it appeared that proportionately a larger number did seem to seek care through the vet center program rather than through the Veterans' Administration.

The factors that may be influencing that are complex, and they do deserve study. We do know that the majority of women Vietnam veterans were nurses and do have a high educational and presumably economic income level. There is some thought that they may be seeking private care; but we don't know that for sure. These are some of the things we want to look at.

They do have a tendency to perhaps be more concerned about having some degree of anonymity in seeking secure forms of treatment for mental health problems. There is also some feeling in the women's Vietnam veteran community that there is both a general ignorance and insensitivity to the overall experience of women veterans and nurses, the experiences that they had in Vietnam and the theater of operations as well as the nature and extent of the stresses involved in combat casualty care and in being a woman in a war zone.

We think that the fact that women have never been involved in any national study, except for the RTI study, kind of underscores that prejudice. There is also some belief that some of the societal stereotypes of women in the military, women in war and PTSD sufferers in general, have been somewhat negative and may be reinforcing an individual's desire to distance themselves from settings where those kinds of negative reactions may recur.

And last, we think that the VA has in the past been generally perceived as a health-care system geared toward providing care to male veterans. This is complicated by what in the past has been a lack of availability of gender specific health care and facilities capable of providing equal access to care for women.

The VA has made some strides in this area, to improve its ability to care for women, but we do believe that it will take some time for the VA to counter the image of its being a male-oriented service and make women comfortable in seeking health care services.

So, those are some of the factors. As I said, the committee's goal for its coming report—should we be extended—is to take a look at our data, the RTI data, and whatever other information we can gather and do a subsection of our report on women and minority veterans.

Chairman **Cranston**. Do you have any suggestions on how the VA can encourage more women veterans to use the VA health-care system, especially for treatment of PTSD and other readjustment problems?

Ms. **Furey**. I believe that one of the ways that this could be improved is through more structured outreach geared toward women veterans, including a recognition and ackowledgement of their experiences and the nature of their service.

One of the problems that women veterans have is that their numbers are small, and so it is not always possible for large numbers of them to be brought together, which has been one of the more acceptable treatments of post-traumatic stress disorder. We do think the possibility of developing occasional weekend retreats or regional get-togethers may facilitate women's ability to receive some peer support, validation, and recognition so that they may benefit from the sharing that the male veterans can by virtue of their numbers.

Chairman CRANSTON. Turning to the issue of PTSD and education, I note that in the special committee's annual report for 1985 and Dr. Friedman's testimony this morning, the committee recommends that the VA engage in national training programs to prepare VA staff to respond effectively to the veteran population suffering from PTSD.

What is the status of the national training program? And do you believe that enough has occurred in that regard?

Ms. FUREY. The committee feels very strongly that the most effective way to address the variability of the diagnosis and clinical activity in PTSD throughout the system is through a national training program. In our 1986 report, we did outline seven areas that we felt needed emphasis. I believe you have them in the report.

We are still attempting to address those seven areas and, therefore, have not been able to address the other areas that have been identified in subsequent reports. We have been hindered somewhat in developing a national training program, particularly this year, as we had no budget; we have no funds specifically allocated for national training in PTSD.

So, we were not really able to get anything off the ground this year until April. We have a few programs that will be implemented before the end of the year.

We have concern for the future for, again, those hospitals and medical centers that have low diagnostic rates. Our preliminary study that we did in 1986 showed that there was a very low rate of codiagnosis of PTSD in alcohol and substance abuse units. We have real concerns about that since alcohol and substance abuse are commonly associated with PTSD. We have concerns about the PTSD treatment teams. We do see these teams as being really the core of a national program and people who can be used as resources within geographical areas to upgrade the general diagnostic and treatment skills of VA health-care providers within those regions.

We also have concerns about the compensation and pension physician examiners and their level of skill and knowledge in assessing PTSD in those patients being reviewed for disability ratings. And with the information from the RTI, of course, the concern regarding women and minorities.

So, although we have a committee, we feel that we do need to have a budget and that this has to be made a priority within the VA in order for us to develop a meaningful program within a reasonable time frame to make some impact on the level of clinical and diagnostic skill.

Chairman CRANSTON. What VA training programs have actually been implemented since the time of the 1985 report?

Ms. FUREY. We have had training programs in all the regions for the chiefs of the clinical services—psychiatry, psychology, social work, and nursing. We had one program for the specialized inpatient treatment programs. We have had some teleconferences for the direct care providers, and we have had special programs geared toward some VA medical centers.

I do have a list which I could submit to you. We had about nine programs, I believe, geared toward particular VA medical centers.

Chairman CRANSTON. Would you provide that for the record?

Ms. FUREY. Yes, sir. We are presently in the process of developing a national teleconference program for nonpsychiatric healthcare providers based on our belief that many of these veterans' initial contact in the Veterans' Administration is made in other than the psychiatric centers.

There are some plans to try to get a program for the PTSD treatment teams done by the end of the fiscal year as well as to develop a video tape for the DM&S examining physicians involved in doing C&P exams. Those are primarily the areas that have been addressed to date.

Chairman CRANSTON. Thank you very much. Finally, I would like to ask you just to respond to this in writing—not verbally presently—with regard to the overall education issue. What do you believe the VA should be focusing on for the future? If you would get that in by July 22, I would appreciate it.

[Subsequently, Ms. Furey furnished the information which appears on p. 315.]

Chairman CRANSTON. That completes my questions to this panel, and I thank each of you for your presence and for your help on this. Thank you.

We now go to our fourth panel, comprised of Dr. Ray Scurfield, Director, PTSD Treatment Program, VA Medical Center, American Lake, Tacoma, WA; Mr. Robert B. Rheault, Outward Bound Program, Rockland, ME; and Dr. Steven Sonnenberg, Joint Commission on Public Affairs, American Psychiatric Association, Washington, DC.

Mr. Gusman has also submitted a prepared statement describing the inpatient program at Menlo Park, which will appear as part of this panel's testimony; and I will ask Mr. Gusman to come forward after the panel's testimony to join in for the questioning.

Dr. Scurfield, if you would begin with the 5 minute summary of your remarks, I would appreciate it.

STATEMENT OF DR. RAYMOND M. SCURFIELD, DIRECTOR, PTST [POST-TRAUMATIC STRESS TREATMENT] PROGRAM, VA MEDICAL CENTER, AMERICAN LAKE, TACOMA, WA

Dr. SCURFIELD. It is a very, very hot, muggy, sweltering, sunny, summer day in July. The year is 1968. I am in Nha Trang, Vietnam, as the social work and executive officer of one of two Army psychiatric teams. After arriving in Nam, I learned the following military/psychiatric principles, which are still in vogue today and which are still part of the major attitude problem that a number of governmental, military, and professional persons have in accepting chronic PTSD as a valid psychiatric disorder.

> This is only a temporary reaction. You are having an acute and understandable response to a stressful situation. It will soon pass. And don't forget, Lieutenant Scurfield, the problems of secondary gain and fixation of neuroses. If you keep a vet away from his duty station too long, it will become increasingly difficult to get him to go back to duty. And if you prematurely evacuate him out of country, his symptoms may well become fixated and permanent. Therefore, return to duty ASAP and only Medevac out-of-country as a last resort.

We never heard about the possibility of chronic, longer term, postwar psychiatric sequillae, unless we Medevaced someone out-of-country "prematurely." Finally, a clear issue oftentimes facing the command structure in Army psychiatric personnel was: Is this vet "crazy," actually out of touch with reality—and of course, we all know that the reality in Vietnam oftentimes was rather bizarre—or is he a malingerer, a malcontent or a weakling and a wimp?

These kinds of prejudicial attitudes pervade today among a number of officials in the DOD mental health professionals and the various governmental agencies, and are quite problematic in terms of getting the right kind of support that programs need.

In 1988, American Lake VA, Tacoma, WA. Current waiting list: 150 veterans, and the number is climbing, representing at least 10 different States. Average waiting time to get into our program: 9 to 10 months. This is due in part to the obvious, tremendous unmet need and in part to our outstanding reputation (which is based upon, No. 1, the fact that we have a great and at least a minimally reasonable number of, staff). We also have gotten excellent support from several of our local VAMC officials; and there are great collaborative relationships with numerous committed and skilled vet center, fee contractor, and other VA and non-VA providers.

The typical vets we see: Army and marine frontline troops; about 60 percent have a history of repeated, acute inpatient hospitalizations and several different outpatient treatment episodes. About 70 percent have had one or more actual suicide attempts—not gestures. We are talking about not putting the gun to your head, putting your finger on the trigger and thinking about pulling the trigger. We are talking about pulling the trigger and then perhaps surviving—70 percent, one or more documented attempts. Also, 66 percent have a dual disorder of substance abuse. And, at least 20 percent clearly require a significantly longer length of stay than our 11 weeks can provide to them.

I can't overemphasize the importance of the adequacy of size and quality of the staff needed to deal with such a concentration of severe, chronic, multiproblematic conditions. This is a very labor-intensive effort.

Finally, in the greater Northeast area, there are also several obviously seriously underserved special populations of war vets, above and beyond the waiting list. Women vets, about whom I offer a specific proposal in my written testimony; ethnic minority vets, vets with PTSD and coexisting psychotic disorders; vets living in relatively isolated and unserved or underserved areas, and World War II, Korean, and post-Vietnam era war vets with PTSD. About 3 percent of our grads are war vets of World War II, Korea, and the Dominican Republic.

As a brief side note, the earlier national study commentaries did not address one point that I would like to suggest be considered; and that is there is a great debate about the actual size of the Vietnam era veteran and Vietnam theater populations. From what I heard earlier, I suspect that the CDC and RTI studies, respectively, used dramatically different estimates of the size of the Vietnam theater population—which will dramatically impact on the incidence and prevalance figures that are projected.

The Lou Harris poll in 1981 or so, and some of our earlier work in Readjustment Counseling Service in VACO in getting the national vietnam veterans readjustment study planning underway, suggests that over 3 million is much closer to the actual figure that served in country and in the contiguous waters and airspace, and not the 2.4 or 2.5 million reported by the DOD.

Chairman CRANSTON. I do have to ask you to observe the 5-minute rule.

Dr. SCURFIELD. Yes, thank you. Finally, the major two points in my testimony—and I would encourage people to read it if they want to get all the details—are No. 1, the devastating impact of the target allowance that goes to the medical center being inadequate to begin with; this results in a local (UAMC) scramble for resources among all the local programs. The special problem of beneficiary travel is particularly difficult on both the veteran and the VA hospital that has a PTSD unit; and the RAM model obviously penalizes long-term programs such as owrs.

There is thus a serious pressure to reduce staff in more "costly" programs, we have had an 18 percent reduction in our staff size in 3 years, vacanies have oftentimes not been backfilled or kept vacant for substantial periods of time. And our length of stay has been reduced a total of 21 percent.

There also is a continuing practice for centralized VA statistics and data typically not to differentiate between war and other era veterans. I would strongly advocate that all of the VA data from all of the departments ought to include this breakdown where there are any kind of significant differences or trends.

In conclusion, out of all the official APA mental disorders, most mental health professionals might agree that PTSD is probably the one disorder, along with head injury precipitated disorders, whose etiology could be actually and rationally linked to military war zone experience per se. Thus, could any VA mandate regarding mental health services deserve to be as high a priority as the treatment of war-related PTSD for all war vets? Not in my opinion. Thank you.

[The prepared statement of Dr. Scurfield appears on p. 347.]

Chairman CRANSTON. All right. Mr. Rheault? Excuse me. First, Senator Mitchell, do you have a statement that you would like to make?

OPENING STATEMENT OF SENATOR MITCHELL

Senator MITCHELL. Mr. Chairman, I do; but in the interest of time, I will place my statement in the record. I apologize for being late; we have had two markups today in the Finance and Environment Committees. I want to welcome Mr. Rheault, who is from the

State of Maine, and who works with the Hurricane Island Outward Bound Program in Rockland, ME. That work is with the PTSD unit at the VA Medical Center in Northampton, MA, and we are grateful to have him here and look forward to hearing from him.

We have another Maine witness who will be testifying also and we will look forward to hearing from, Bob Comeau. I thank you, Mr. Chairman, for inviting these witnesses; I think their testimony will be useful to the committee.

Chairman CRANSTON. Thank you very much, George. Now, Mr. Rheault?

[The prepared statement of Senator Mitchell appears on p. 125.]

STATEMENT OF ROBERT B. RHEAULT, DIRECTOR, HURRICANE ISLAND OUTWARD BOUND PROGRAM, ROCKLAND, ME

Mr. RHEAULT. Thank you, Mr. Chairman and Senator Mitchell and members of the committee. It is a privilege to be here, particularly as a maverick who doesn't have a Ph.D. or an M.D. after his name, and does not work for the Veterans' Administration. I work for outward bound, as Senator Mitchell mentioned. I am a Vietnam veteran, and I do run a program for veterans suffering from post-traumatic stress.

The Outward Bound Program that we run is an adjunctive therapy program, and I underline the word "adjunctive" for what we do is not a magic trick in isolation, but something that serves as a catalyst and an expediter for the work that is being done in the inpatient units.

We have found that it is powerful, and it is cost effective. Let me explain a little bit about what we do.

We are dealing with the most severely affected vets, those who are in the inpatient units, those men whose lives are in disorder, who cannot lead normal lives; and yet these are not hopeless cases. These men are good guys; they are people I served with in Vietnam, and I have led some 30 groups of these men into the boondocks again.

I know that they can make it, but they do need help. Now, what do we do?

We take the vets out of an inpatient unit, out of the hospital into the wilderness for a short duration, 4 days and 4 nights. We camp out, backpack, climb mountains, do repelling, and technical rock climbing on vertical cliff faces; and we do a lot of talking and a lot of debriefing.

The course is deliberately tough and stressful, but it is designed for success. What the vets learn—or I should say what they relearn—is that they can do difficult things, that they can stick with a difficult task through to completion, that they can get close to others, trust other people, help one another, and that they can be responsible for their own lives.

No matter how good a hospital program may be, a hospital is an institution; and institutions rob men of their sense of responsibility. "They" take care of me; "they" tell me where to go, where to sleep, when to get up, where to eat; "they" run my life and schedule my days. Life becomes passive and inactive.

By taking men out of the hospital and into the field, we can break that debilitating cycle of dependency which we call institutionalization. Further, because the experience is powerful and it is dramatic, the vets return to the hospital energized and really ready to work and to work hard in therapy.

I didn't know that Ray Scurfield was going to be sitting beside me today. I wanted to quote from his words, so there would be somebody who did have a Ph.D. or M.D. after his name. And here is what he wrote:

> The Outward Bound experiences were remarkable in terms of the impact on the group and on the individuals. The group bonding and cohesion was dramatically accelerated in quality and extent, above and beyond that ever achieved by any other group in the program. The results were demonstrated in very significant therapeutic achievements in subsequent group therapy sessions.

And he goes on and on. His final words are:

> All in all, I can't imagine a more positively impactful, dollar for dollar, component to a PTSD rehabilitation program.

I have countless letters and many of them are in the written testimony I have provided to the committee from people, on the clinical side of the house, who work with vets and who testify to the effectiveness of this program.

I also have many letters from the vets themselves who rate outward bound as having been the most powerful part of their therapeutic achievement. This is all in the written testimony.

In other words, what I am saying is that the program works. We in outward bound are now running two of these programs—and only two—one in Northampton, MA, and one in Tacoma, WA. A third will start in September in Augusta, GA.

And all of this is being paid for with privately raised money; none of it is being paid for by the VA. It costs less than half as much to take a vet to the field than it does to keep him in the hospital.

I submit that, if the effect of this program is sufficient, then it doesn't take more money to provide a wilderness experience as part of the therapeutic treatment, that one could use this as a catalyst—as an expediter—as I have said, to function in a lot more different areas.

Outward bound is a national organization. We have five schools spread around the country. We know that we can do this, and we can train others to do it as well. We have proved that it works; we have been doing it for 5 years in Northampton and are now in our second year in Tacoma.

We have proved that it is cost effective. We should be getting on with it, and we should be doing it in a lot more places.

This morning, I went down—as is my wont, when I am in Washington—I took a run down to the wall to salute the names of many of my comrades that are inscribed there. It is a beautiful memorial, and it is an appropriate one; and I am glad it is there. I would also like to be doing more for the vets who are here alive. Thank you.

Chairman CRANSTON. Thank you very much. Dr. Sonnenberg?

[The prepared statement of Mr. Rheault appears on p. 367.]

STATEMENT OF DR. STEPHEN SONNENBERG, JOINT COMMISSION ON PUBLIC AFFAIRS, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. SONNENBERG. Mr. Chairman, Senator Mitchell, I am Stephen Sonnenberg, M.D. I am in the private practice of psychiatry in Washington, DC. I hold and have held various academic and research positions which have brought me in contact with those who suffer from PTSD, and I have developed innovative service programs for Vietnam veterans with PTSD. Finally, I was senior editor of the book, "The Trauma of War: Stress and Recovery in Viet Nam Veterans."

I am testifying today on behalf of the American Psychiatric Association, a medical specialty society representing over 34,000 psychiatrists nationwide. The association, reflecting the experiences of its members, is concerned that the very best psychiatric services be available to our veterans of war with PTSD.

I had the privilege of addressing this committee 7 years ago when we knew far less about PTSD and its effect on Vietnam veterans. I consider it an unusual and important opportunity to speak to you again and to convey to you the essence of what I and my colleagues have learned about PTSD since 1981.

I am afraid that my view of PTSD is less optimistic now. Once I believed that the condition might often be treated definitively, be permanently cured, if enough well-trained professionals were available to offer appropriate psychiatric treatments to the PTSD patient population.

I thought that psychological insight on the part of many PTSD sufferers would produce many cures. Now, my perspective has shifted. Seven years ago, I suggested that PTSD might produce and be perpetuated by a basic, fundamental change in the chemical and biological functioning of the brains of those who developed it. Now, there is much more research and clinical evidence which supports that view.

But beyond that, today we realize that because of the interplay of basic biological and psychological forces, definitive cure is also an illusive goal. The condition then is now understood as the end result of both biological and psychological factors. This means that biological and psychological predispositions, specific forms of trauma, and ongoing life experiences all converge to produce what in a given sufferer is an unpredictable clinical picture and course.

The point is this: Psychological insight alone does not offer the promise of consistent, definitive, permanent cure. Some will be made well again; but for many, ongoing professional assistance will be required. Thus, a full range of excellent treatment options must always be readily available for those our society sent to war. And there are no shortcuts.

A given Vietnam veteran with PTSD, or a given veteran of another war with PTSD, may suffer acutely or chronically, consistently or intermittently, or just once in his or her life. Some sufferers will require inpatient treatment, some outpatient treatment. Some will require concurrent drug and alcohol abuse treatment; some extensive community-based care after hospitalization; some peer group counseling; some medication; and some long-term indepth individual psychotherapy.

Vietnam veterans are approaching midlife, and that means that special attention must be paid to the confluence of the expected developmental challenges of that period of life, superimposed on an ongoing struggle with the aftermath of psychic trauma.

We must be aware, then, that we may find that Vietnam veterans with PTSD develop more psychological difficulties in midlife than do their peers. We must be prepared to treat those who so suffer.

Now, I should like to comment on the role of the Congress. I believe that the ongoing exercise of your oversight function is terribly important. You both lead the American people and express the will of the people; and your interest and support help to counteract psychological forces which predispose all individuals and all communities to forget that which is psychologically painful.

That certainly applies to our pain, in recognizing the pain of so many of our veterans of war. Really, regardless of our conscious concerns, unconscious forces militate in favor of our forgetting their suffering. Your activity is an antidote to this tendency.

I believe you know that your interest will spur the Veterans' Administration, and the entire mental health-care delivery system, to continue essential efforts in professional training and education, research, and service provision in the area of PTSD. And I am sure you know that the fiscal support of the Congress is also necessary in that regard.

I know that today represents the continuation of what will go on being the concerned exercise of your oversight function, and is in no way an ending. Everything I see and hear tells me that is so, and I want you to know that in the future, as now and as in the past, I stand ready to assist you on behalf of my colleagues, and the veterans we serve, in any way that I can.

Chairman CRANSTON. Thank you very much.

[The prepared statement of Dr. Sonnenberg appears on p. 395.]

Chairman CRANSTON. I will start with some questions for you, Dr. Scurfield. GAO has reported that certain changes have been made to PTSD treatment programs in response to the RAM. One of these changes is the implementation of a 3-day assessment period, which your program at American Lake utilizes.

Another change the GAO reported is shortening of the length of stay to gain greater reimbursement under the RAM. When you shortened the length of stay at American Lake, were you under the impression that your program would then receive more beneficial reimbursements under the RAM? And if so, are you surprised to learn from the GAO that, in fact, shortening the length of stay as you did had the opposite effect?

Dr. SCURFIELD. I am totally shocked. Yes. We were told that that would increase revenues. More importantly, the calculations both by local officials and by our program led us to believe that very strongly, and so that was the response.

Chairman CRANSTON. Do you plan then to reconsider your program's length?

Dr. SCURFIELD. We are certainly going to look at it. The other problem with length of stay is, when you have 150 vets on the waiting list, we have to make decisions between how long to keep the vets we have versus how many more are out there that we need to see, and so forth. So, we will look at it carefully, but the likelihood might be to raise it slightly if the GAO calculations can be verified.

Chairman **Cranston**. Ray, in your testimony, you state: "We discovered after the first year of operation that our assumption that we could devote little effort to outpatient aftercare treatment was incorrect." Would you please elaborate a little bit on that discovery and tell how aftercare is now handled at your facility?

Dr. **Scurfield**. Yes. No. 1 is that to call these "designated inpatient programs" is a misnomer. We are a comprehensive, prebed, inpatient, and aftercare program; and that wasn't how we thought originally. What we found is that, No. 1, the majority of the vets that we see, while not from the immediate area, also are not necessarily geographically accessible to any other available PTSD resources.

As a result, a number chose to relocate to get closer to resources—some closer to us, some closer to vet centers, for example. We found that a number of the vets bonded with us to a degree that they felt that they would rather stay in treatment with us to maintain the continuity of care.

There were also other vets who reported to us that at some of the resources they went back to, the veterans' level of stress recovery and commitment to recovery at those particular places wasn't what these vets were now used to; and so, there was some or considerable disappointment about what was available for PTSD aftercare treatment.

The other part of it is that there just are not enough PTSD knowledgeable outpatient resources, period. So, we are worried that some vets dropped out of treatment and wouldn't go and connect with anybody again for aftercare. We see the inpatient phase as just one piece; every vet we see is required to be in outpatient treatment with somebody prior to being considered for our program, and we strongly urge them to go into outpatient treatment after they leave us. If they don't do that, their inpatient gains can be seriously undermined; and they have difficulties moving on with the other issues in life that they need to work on as well.

Chairman **Cranston**. Thank you. Mr. Rheault, using the Outward Bound Program as a component of treatment for PTSD is an interesting concept. I congratulate you on your involvement in helping Vietnam veterans, as you have, and your deep dedication to that purpose.

You note in your written testimony that the VA has not provided any funding for your program, but that it is funded entirely from private sources. Can you tell us where that private funding comes from?

Mr. **Rheault**. Yes, sir. I should say that, at one time, the VA did provide one block of money to run a program for 1 year, but those funds dried up. The privately raised money that I am talking about comes from individuals, from corporations, from foundations; and I would like to recognize particularly the Disabled American Veterans who have been one of the big donors to this program, and the Paralyzed Veterans of America who have assisted me in raising money. I am not a good fundraiser; I am basically a field soldier.

The Welcome Home Fund, which raised some money, gave us a major grant. This grant was received with the help of the Paralyzed Veterans of America, and this was the money that has enabled us to get the program going again in Tacoma, WA, and will enable us to open a second program in Augusta, GA, in September.

But it is mostly the generosity of individuals and some foundations; and, as I say, the Disabled American Veterans have been the single largest financial supporter of this organization.

The other veterans' organizations, I regret to say, have not helped out.

Chairman CRANSTON. Thank you very much. George, I would like to yield to you for any questions.

Senator MITCHELL. Thank you very much, Mr. Chairman. Mr. Rheault, in your written testimony, you mention three VA medical centers that have incorporated the Outward Bound Program into their PTSD treatment programs—in Northampton, MA; Washington State; and Georgia. I am curious; has the VA center in Maine expressed any interest in your program?

Mr. RHEAULT. I have been in touch with the hospital in Maine from the very beginning. The original director of the PTSD unit there was the man with whom I started the program at Northampton. I regret to say that we were never able to bring that to fruition because the center there and the hospital there was in some disarray.

I met just 3 or 4 days ago with the Chief of Psychiatry and the Director of the Post-Traumatic Stress Unit; and we now feel that they are squared away enough that we can once again consider running a program. I have committed myself in support of Togus starting in May of next year, and I don't know where the money is going to come from. I have just said we will do it; we will sell pencils on the street or whatever is necessary to get it going.

Senator MITCHELL. Would you take it upon yourself to keep me informed in writing as to the progress of that and, at the latest next year, if you do become directly involved and let me know that as well?

Mr. RHEAULT. Yes. I am going to stay in close contact with Togus from now on. I now feel that there is sufficient stability there that we can get something going. There was a lot of turnover of staff in that hospital, and we just couldn't get well enough organized to start something.

I did not want to start an Outward Bound Program if they were not squared away.

Senator MITCHELL. Yes. That seems to have stabilized under Mr. Holthouse.

Mr. RHEAULT. Yes, I think so.

Senator MITCHELL. I will look forward to hearing from you. Thank you very much, Mr. Chairman.

Chairman CRANSTON. Do you want to introduce Mr. Comeau at this time.

Senator MITCHELL. Yes. Mr. Chairman, as I indicated earlier, I am unfortunately involved in a committee meeting that I am chairing and to which I must return.

That is why I was late and can't stay, but there are actually two other witnesses, whom I would like to mention here. Bob Comeau is a team leader at the Portland, ME, Veterans Center, and Steve Bentley is the national chairman of the Vietnam Veterans of

America Special Committee on PTSD and Substance Abuse. I know both Bob and Steve and have met and talked with them on several previous occasions.

We have a very active and, I believe, good program in Maine, Mr. Chairman; and they will provide information on both the strengths and weaknesses and some of the things that they are trying to do in Maine that will, I believe, be useful to the committee.

I talked with Bob yesterday; I haven't seen Steve except to see him in the audience now. I apologize to both of them that I cannot stay for their testimony, but I will review it along with that of others; and I look forward to working with you, Mr. Chairman, on a continuing basis in this area.

I thank you very much for your courtesy to me, Mr. Chairman.

Chairman CRANSTON. Thank you very much. Mr. Rheault, I had some questions, but I am going to submit them in writing to you. Thank you very much.

Dr. Sonnenberg, you mention in your testimony that Vietnam veterans may be at an increased risk for psychological difficulties as they approach midlife. Could you elaborate as to what these difficulties are and why risk increases at midlife?

Dr. SONNENBERG. We know that developmentally when people approach midlife there are many aspects of their identities which they question; and there are, reflecting this, higher rates of divorce, suicide, various reflections of psychological turmoil. My concern is that when the Vietnam veteran approaches midlife and struggles with these developmental challenges, he will be, in a sense, playing with an incomplete deck.

He is already stressed because he is trying to deal with the trauma of his past experience. It is more difficult for him to deal with the increasing stresses of the aging process—of the midlife aging process.

I don't think we really know definitively what to expect, but I think we have to be aware that this is something we have to look at very carefully.

Chairman CRANSTON. Based on your previous experience, what do you consider the most effective and the least effective treatment modalities for PTSD?

Dr. SONNENBERG. I think that depends on the particular veteran. There is no question but that the peer group counseling program has been the backbone of treatment; but I think that for a given veteran, inpatient treatment may be absolutely essential. For many veterans, alcohol and drug abuse treatment is essential.

I think we are going to find that family counseling programs may be extremely important. As a clinician all that is my message to you. We have to be prepared to encounter each veteran as an individual, and recognize that there may be a broad range of specific needs that a given veteran will have, as we look down the road. And we are looking down a road that will extend for several decades.

Chairman CRANSTON. I thank each of you very much, and I do want to ask Fred Gusman one question, which I would like an answer in writing, not verbally. I want to thank you, too, Fred, for your very effective leadership and your work in California on this matter.

Fred, in your written testimony, you indicate that Menlo Park is engaged in experimental treatment of the dual diagnosis of PTSD and alcoholism; and I would like you to explain in writing for us what that treatment entails. If you can do that by July 22, please?

[Subsequently, Mr. Gusman furnished the information which appears on p. 340.]

Chairman CRANSTON. I thank each of you for your very helpful presence today, for your testimony, and for the work you are all doing.

We now come to our fifth panel, consisting of four team leaders from four vet centers across the country, who have been asked to be here today to respond to questions regarding readjustment counseling programs and PTSD.

These gentlemen are Bob Comeau from the Portland, ME, Veterans' Center; Mr. Obed Fernandez from the Fresno, CA, Veterans' Center; Mr. Bob Meredith from the Cheyenne, WY, Veterans' Center; and Mr. Harry Doughty from the New Orleans, LA, Veterans' Center.

Since you don't have any opening prepared statements, I will proceed at once to questions. Before we get started with the questions, let me say that if any of you have a comment you would like to make on a question I direct to one of the other panelists, please try to indicate that to me and I will try to give you an opportunity to speak. Although we are running short of time, I do want to elicit your views. I also invite you to supplement any answers you provide today or that you would have, had we had time, by sending the committee written comments and additional thoughts on the questions that we get into.

First, one of the concerns that has been raised by the Advisory Committee on PTSD is the extent and effectiveness of the collaboration between the vet centers and the supporting medical centers. What have been your experiences with VA medical centers in terms of their ability to provide appropriate, timely mental health services for Vietnam veterans suffering from PTSD when your center made referrals to the medical center because you believed the problems were beyond your capacity to treat effectively? How has all that worked? Any one of you want to start with a comment?

TESTIMONY OF BOB MEREDITH, TEAM LEADER, VET CENTER, CHEYENNE, WY

Mr. MEREDITH. I am currently working at the Cheyenne vet center in Cheyenne, WY; and we have an extremely good relationship with the VA hospital there. When we encounter PTSD cases that we feel we need some help with, we have a contact person at the hospital, the chief of psychiatry, and she is very, very helpful to us.

Chairman CRANSTON. Any other points of view you want to express? If not, think about it and respond in writing later if you wish.

Harry, how important is it to what you do with the veterans to have a good relationship between vet centers and medical centers?

TESTIMONY OF HARRY DOUGHTY, TEAM LEADER, VET CENTER, NEW ORLEANS, LA

Mr. DOUGHTY. Senator, I think it is very important that we understand the mission of the vet center, as well as the medical center; and I am pleased to say that, since 1980, I have enjoyed a very close working relationship with my particular medical center.

[The prepared followup statement of Mr. Doughty appears on p. 589.]

Chairman CRANSTON. If each of you would comment either now or in writing, if you would prefer, on your relationships with your medical centers and whether you believe your experiences are generally typical or whether there is something unique about them.

TESTIMONY OF OBED FERNANDEZ, TEAM LEADER, VET CENTER, FRESNO, CA

Mr. FERNANDEZ. I would like to add that having worked for the Veterans' Administration for a number of years has enabled me to, I think, develop a very close working relationship with the medical centers. And also, I would like to resound what my colleagues here have said that, by knowing the people who are involved in the treatment process, it enables us to move our veterans who are in need of intense care in smoothly.

Chairman CRANSTON. Do any of you have any suggestions on how to improve these relationships generally across the country?

[No response.]

Chairman CRANSTON. Why don't you think about that? Oh, you have one now?

Mr. MEREDITH. Yes, sir. One of the things that it seems to me would be very appropriate is for the VA hospital medical staffs—psychiatry units, psychology units, whatever—to be in more close contact with the vet centers. It is important for vet centers to make this contact as well.

Chairman CRANSTON. Thank you. The next question I direct to the two of you who are "Bobs," Bob Meredith and Bob Comeau. Given the population configuration of Wyoming and Maine, are there problems with the veterans getting to the vet centers for treatment?

TESTIMONY OF BOB COMEAU, TEAM LEADER, VET CENTER, PORTLAND, ME

Mr. COMEAU. Yes, Mr. Chairman. One of the main problems that we have had in Maine during the 9 years I have been with the vet center program, our vet center opened, by the way, very shortly after the vet center was authorized by Congress in 1979, is that our population in Maine is small and is widely scattered.

Though we have a vet center in Portland, ME, the largest city in the State, and a vet center in Bangor, ME, it has been very difficult for veterans in the outlying areas of the State to reach the vet centers.

My colleague, Joe DeGrasse, in Bangor encounters that situation even more frequently than I do. He has some clients who come from the upper areas of the State, near the Canadian border; and for some of those veterans—to give you an example geographically—it takes as long for them to reach Bangor as it takes me to reach New York City from Portland. It is virtually impossible for some veterans to utilize these resources when you consider that they may be the ones that are most affected by PTSD, and often have the least available resources. So, for them, the loss of beneficiary travel is especially significant.

As a matter of fact, within the regulations of the vet center program, unless the client is service connected and is going to the VA medical center, they are not eligible for beneficiary travel. So, unless there is some way for them to get travel moneys, they often cannot come at all.

Chairman CRANSTON. How about Wyoming?

Mr. MEREDITH. Basically, I can echo what Bob is saying here. We find it extremely difficult, located in Cheyenne. We have been involved in outreach to areas like Jackson and Cody, and those areas are at least 6 to 8 hours away. So, if we travel to those places or they travel to us, we end up having to first of all calm somebody down after an 8 to 10 hour trip, and he is probably already pretty excited before he has ever embarked upon this adventure.

This is one more frustration, I think, that he feels with the system. The Vietnam veterans oftentimes feel alienated already; and when he has to drive or feel like no one again really cares, then that adds to that alienation and frustration. So, our efforts would indicate it is more difficult to reach these folks.

Mr. COMEAU. Mr. Chairman?

Chairman CRANSTON. Yes?

Mr. COMEAU. May I comment on some aspects of that?

Chairman CRANSTON. Sure.

Mr. COMEAU. One of the most important aspects of the vet center program for the vet centers in Maine, has been our contract program, a program that has been somewhat controversial in other areas of the country. In our case, we are desperately in need of our contract program. Unless we are able to hire contractors in outlying areas of the State to see a small number of Vietnam veterans, these veterans will not receive treatment. Many of these contractors only see two or three veterans, and while that may not seem to be cost effective, it actually is surprisingly cost effective. Without that ability, we would be unable to serve those veterans at all.

Chairman CRANSTON. I would like each of you now to address the question I am going to ask, in turn. Who in your vet center is qualified to and is actually making diagnosis of PTSD? Would you start, Harry?

Mr. DOUGHTY. Certainly. I would like to think that I am certainly qualified by training and having been in the program for 8 years. In addition, we have another full-time social worker on staff, a part-time psychologist, and a full-time clinical psychologist as well. So, we have four professional DM&S qualified individuals who could make those distinctions as needed.

Mr. FERNANDEZ. In Fresno, CA, we have myself, a DM&S qualified master of social work as team leader. We also have a clinical coordinator by the name of Ken Hall, who has also received his master's degree in social work. Several years of experience, I think, enable us to make those assessments.

And in addition to that, we also have contractors or consultants who come in and assist us in these assessments who include psychologists and psychiatrists from the medical center as well.

Chairman CRANSTON. Thank you. I appreciate your coming all the way from Fresno, incidentally.

Mr. FERNANDEZ. Thank you.

Chairman CRANSTON. Bob?

Mr. MEREDITH. At the Cheyenne vet center, we have a clinical coordinator who is a master of social work. I have worked for the vet center for 3 years. I am not DM&S qualified but have worked with veterans for a considerable amount of time. So, we have adequate staffing, we feel, too.

Chairman CRANSTON. Bob?

Mr. COMEAU. Regarding the staffing of the Portland, ME vet center: I am a licensed clinical social worker, and have 9 years experience. I also have clinical privileges through the chief of staff. Molly Stanley is a licensed clinical social worker; she is clinical coordinator of the vet center. Jack Ritchie, who is an R.N. and MSED, is also qualified. So, we have three fully qualified individuals.

Chairman CRANSTON. For those of you who are making PTSD diagnoses at your vet centers, how readily are those diagnoses being accepted by the medical center or by the Department of Veterans' Benefits for claims adjudication purposes?

Mr. DOUGHTY. I think in New Orleans we have a unique situation in that the chief of psychology has been very supportive of our mission and has been actively involved in seeing ex-POW's, many of whom are suffering from the same kind of disorder as Vietnam veterans have. And I along with our staff and other mental health professionals at the medical center have been very effective in identifying and diagnosing PTSD.

We have had an increase in the number of cases that have been adjudicated previously on behalf of the veteran in the last 18 months.

Chairman CRANSTON. Obed?

Mr. FERNANDEZ. Although I can't share any particular statistics on the particular numbers, I recognize that when someone is rejected for one of those claims, I hear about it. And at this particular time, I am working with two individuals who have essentially been rejected for their PTSD claims.

So, that would suggest to me that our success ratio on the claims that we have submitted are substantial. Part of the reason that I think our vet center is quite successful also has to do with the availability of a national service officer that we have occupying one of our offices, and that is Mr. Lupe Alonzo who is working for the Military Order of the Purple Heart. In that capacity, he is well able to assist veterans with their claims and does an excellent job at followup.

Chairman CRANSTON. Bob Comeau?

Mr. COMEAU. DM&S has always readily accepted our diagnosis of PTSD and has been very helpful. We have had a very close collaboration with them through our liason officer, Dr. Philip Pierce, who is also Chief of Psychology Service. But regarding DVB, I think that something that should be said is that we have made a real effort in the Portland Vet Center to stay as far outside of that area as we possibly can. We learned many years ago that it was destructive to the therapeutic process within the vet center to be identified as part of the claims system. So what we do instead is refer the veterans whenever possible. We have an in-house DVB staff member, Doreen Morrell, at the vet center, who is very knowledgeable in the claims area. The veterans' service representatives are also very helpful in setting up claims.

And then, the veterans working through DVB can come back to us for evidence; but we don't initiate that with DVB.

Chairman CRANSTON. I would like to ask each of you now—and I will start with Bob Meredith—to describe the counseling available specifically for PTSD at your vet center.

Mr. MEREDITH. Primarily at our vet center, we use the group counseling technique, but we also provide an individual counseling; and, since we are located close to a VA facility, we offer a quick referral to the VA medical facility in terms of alcohol rehabilitation or more severe psychiatric type cases that we may encounter.

But the primary method of treatment that we use is the group process.

Chairman CRANSTON. Bob Comeau, do you have a comment?

Mr. COMEAU. I would like to say that partly our vet center has been successful in Portland because we have a client-centered problem orientation. When a Vietnam veteran comes in to our center, he often comes in with a distinct problem; and we have learned that we have to address that problem, whatever that might be, before we do anything else. It may be many weeks before we address other issues.

Contrary to some opinions about how one should go about it, we found it best for us to work on the presenting problem, no matter what that is—no matter if it seems to be far removed from Vietnam. For instance, if it is a housing problem, if the veteran is living in the street, we must address that problem first.

If the veteran has a medical problem or a problem with adjudication, we help the veteran with that; and by this approach, we start to build trust. We start out with an individual process as often as we can, working eventually toward group therapy because we can't treat all the veterans who need to be seen as individuals with our small staff. So, that is how we progress.

Chairman CRANSTON. Let me say that I appreciate the brevity of your responses. You are enabling us to cover a lot of ground, and I appreciate it.

Mr. FERNANDEZ. Thank you. We also provide a variety of groups at the vet center at Fresno. These include a psychotherapy combat veterans' group. We have two PTSD groups that also continue on; we call those extension groups. We have a coming home group which is basically an AA philosophy group; and then we have also a relaxation group.

Mr. DOUGHTY. Senator, we are currently conducting four groups per week; and because of limited resources, we found the group method to be very effective. We also offer individual, couples, and family counseling, depending on the need of the veteran and where he is at any particular stage in treatment.

Primarily, our treatment approach is very flexible in meeting the needs of the veteran and his family.

Chairman CRANSTON. Again a question I would like each of you to address. Regarding VA compensation for PTSD, what comments do each of you have on the fairness and appropriateness of VA claims decisions in this area? And what is your personal position on whether veterans with PTSD should be encouraged to apply for disability compensation? Let me start with you, Bob.

Mr. COMEAU. That is an extremely difficult question. We make a joint decision with the client that some veterans should apply for compensation. Those that do, we find often have very little or no resources in the community. Many times they have been unable to work and have made many attempts at job finding, but have not been successful.

Their families are often in distress; they are often in deep financial distress by the time they come to us. And then, of course, we are talking about a 4- to 6-month period for a claim to be adjudicated. It is a very slow process. So, we find with these veterans that we have to begin the process right away.

I do want to say, though, that that claims process completely stops the therapeutic process. We explain that to the veteran. It is a decision; it is a painful decision that I have to make as team leader realizing that some veterans will wait for to begin therapy until after the compensation decision has been made.

As far as the fairness about decisions, it has been puzzling to me over the years; and I have never been able to totally figure it out. There are some veterans whom I feel should be compensated and are not, and there are some veterans whom I feel are compensated and should not be. It is really very difficult.

Chairman CRANSTON. Bob?

Mr. MEREDITH. Again an extremely difficult question. It seems to me that oftentimes what we run into—again to paraphrase Bob's statement—is that we make a decision. If a veteran is coming in and he is under a lot of stress already, we are aware that this is going to be an even more severely stressful situation for him. Therefore, he may not be able to handle the whole process.

At our VA facility, the people in adjudication have been working with us fairly closely; but the rate of PTSD claims is still very, very low. Only approximately 5 to 10 percent of the people who apply are granted even a 10-percent claim. Therefore, we find it very difficult to say yes, we think you should be involved in a PTSD claim because this individual is going to basically just apply a whole lot more stress to himself.

So, again, if we do that, then we have to deal with the process of going through the claim process, and the therapy process basically stops. I really find it difficult to make a personal comment because, again, there are people who deserve to have a PTSD claim granted.

An individual who has suffered the symptoms and been taken out of society should be given a chance to start over. Again, we also see that there are folks who should not be granted claims but are. Thank you.

Chairman CRANSTON. Obed?

Mr. **Fernandez**. I would also like to agree with the statements that have been made already. PTSD, as you know, is relatively new as a diagnosis, and perhaps this is why we are encountering some of the problems we do. I do recognize that if a psychiatrist makes a diagnosis of schizophrenia, the veteran generally gets that compensation forthwith. It is not so as easily with the PTSD claims.

Chairman **Cranston**. I have to go out for a phone call, and Jon Steinberg will carry on briefly.

Mr. **Steinberg**. Harry, would you like to answer that question, please?

Mr. **Doughty**. Sure. I think it is very important as therapists that we stay away from the whole issue of adjudication within our centers. Obviously, there are some vets who need to have their claims adjudicated; and what we basically do is try to do a thorough assessment, present the facts, and have the veteran interface with the DVB side of the administration, as opposed to our getting directly involved with that process.

Mr. **Steinberg**. Again, a question for each of you, and if you would try and answer briefly? Are you encountering more veterans who are seeking help than you have the resources to help? And do you believe many of these veterans have PTSD? Obed, we will start with you.

Mr. **Fernandez**. I believe we are. I started as a team leader at the vet center in Fresno last August when I looked at my monthly report, it indicated that we were seeing approximately 45 new veterans per month.

At the present time, the average has risen to just about 50. I don't know what the reason is except that I have recognized that on public television, there have been a lot of things happening like the movies that have been presented; and I know that that is one of the things that my veterans talk about a lot. "I saw that on TV, and I just had to come in."

Mr. **Steinberg**. Do you believe that there are a substantial number of these veterans who may have PTSD? Do you have any basis for that?

Mr. **Fernandez**. Yes, I believe so. There is a substantial number.

Mr. **Steinberg**. Bob Comeau?

Mr. **Comeau**. It is very interesting—and I am glad my colleague mentioned the SARS [service activity report] report—that 1 month, we saw 80 new clients; and I was really concerned. I think it is important for the record that we have a staff of four—really a clinical staff of three and I wondered what I do if, of those 80 clients, any number of them had remained as continuing clients. I was actually lucky in this case that they didn't.

Every month, by requirement, we have to see 30 new clients. If that happens and we end up with these clients in treatment, I don't always know where or when that treatment will be given. What happens, and I think it is important in talking about PTSD, is that the idea of chronicity seems to have slipped through the cracks years ago.

When I first joined the vet center program, the idea or the philosophy seemed to be that we would see a tremendous number of Vietnam veterans, and we would see them at the most about three times. That has never happened in the history of this program, at least as far as I know it.

What happens is we often see Vietnam veterans in treatment literally for years, and that has caused a funnel effect. The only way that I can describe it is that there is a funnel effect; eventually, we will have more veterans than we can ever treat, and they continue to come in daily.

I just want to say something, counsel, while I have the opportunity. One of the ways we are seeing more and more Vietnam veterans is that we are receiving more calls from spouses, and these spouses are coming in to the vet center.

Their spouses are coming in, sometimes more frequently than Vietnam veterans; and what they say is "my husband doesn't want to have anything to do with you because he does not want to feel weak and that he can't make it. I don't know what to do. My children and I are really suffering from this. What can I do?"

We have a spouses' group that we have run for several years, and it is probably one of our most popular services.

Mr. STEINBERG. Is this a phenomenon that any others of you are experiencing in terms of the spouses? And we will get to each of you also on the main question.

Mr. MEREDITH. I would like to address the question of families because I think that one of the more intriguing aspects of recent developments in our vet center is that families are being seen more and more. By families, I am not just including the spouse; we are seeing an increase in problems with children that I believe, at least in some part, are spawned by dad's behavior at home, either through the anger, the alienation, or whatever.

So, I have to agree that I think the numbers are up especially in terms of the family members.

Mr. STEINBERG. Harry, do you want to comment on that?

Mr. DOUGHTY. Yes. Over the last year, we have noted that the amount of contacts with family members has increased from roughly 5 percent to somewhere between 10 and 12 percent. I think with recent movies, such as "Hamburger Hill," "Platoon," and the TV show, "Tour of Duty," many Vietnam vets who had buried Vietnam are now being faced with that experience again through those movies.

Consequently, we are seeing more severe cases of PTSD.

Mr. STEINBERG. And are you experiencing a volume that is greater than you have the capacity to deal with at this point in general?

Mr. DOUGHTY. In December 1986, our caseload averaged 50 new vets per month and 417 visits. As of June of this year, we had 60 new vets per month and 502 visits.

Mr. STEINBERG. Moving on to another question. In S. 2011, a bill that this committee recently approved and which will be going to the Senate floor shortly, there is a provision that Senator Cranston proposed to expand the eligibility for vet center treatment to include Korean conflict and World War II veterans who seek help. Very briefly, what are the views of each of you on such eligibility? Harry, we will start with you and just go down the panel.

Mr. DOUGHTY. Currently, our clientele are 18 percent non-Vietnam era vets, and I do feel that there is a place in the vet center program for these other era vets.

Mr. **Steinberg**. Obed?

Mr. **Fernandez**. We, too, at Fresno are beginning to see larger numbers of Korean war and World War II veterans. I have been personally involved in providing services at the medical center for a POW group that includes about 30 World War II veterans.

Mr. **Steinberg**. The POW's presently have separate eligibility for readjustment counseling?

Mr. **Fernandez**. Correct, yes. I would say that we are probably seeing about a 5-percent increase in our workload as a result of Korean and World War II veterans.

Mr. **Steinberg**. So, you are currently doing it at this point?

Mr. **Fernandez**. Yes.

Mr. **Steinberg**. Bob?

Mr. **Meredith**. I don't have any specific percentage figures, but we, too, have seen more Korean era veterans at this point than World War II veterans. But again, we have been involved in some cases with World War II POW's.

Mr. **Steinberg**. Bob?

Mr. **Comeau**. We have also been seeing World War II and Korean veterans ever since we opened, as part of our caseload. There has also been an increasing number of those referrals in the World War II and Korean veterans from the medical center.

Mr. **Steinberg**. Also in that bill, as the committee approved it, is a provision to require the VA to give priority care for PTSD—and we are talking here about mental health services—to any Vietnam veteran who has been diagnosed by a designated VA mental health professional as having PTSD without that veteran first having to be formally adjudicated as service connected.

We would like to know what your views are on that proposal. Bob, let's start with you and go down.

Mr. **Comeau**. In our case in Maine, that would probably have little or no effect on the care given to Vietnam veterans as, at the present time, they are receiving what amounts to priority service at the medical center.

The medical center, under the direction of Director Thomas Holthaus, has very deliberately skewed its services toward Vietnam veterans in the mental health clinic, and they have made some great changes in the intake procedure, both medically and psychiatrically.

Mr. **Steinberg**. Isn't there a waiting list for admission to the inpatient unit at Togus?

Mr. **Comeau**. Yes, there is, but I don't know how those two things align, unless that unit is made larger, how would priority treatment affect that?

Mr. **Steinberg**. That is the implication of what this provision calls for in terms of assigning that priority.

Mr. **Comeau**. I see. In that case, it would be a big help, if that were what would happen.

Mr. **Steinberg**. Bob?

Mr. **Meredith**. Basically, we work through the chief of psychiatry at the VA hospital in Cheyenne; and we are in the process of developing, I believe, a really fine working relationship with them at this point. There are no inpatient treatment centers within a reasonable distance from Cheyenne, unless we go to Menlo Park, CA or possibly American Lake, WA.

Mr. STEINBERG. Do you have difficulty getting admissions to either of those facilities for your veterans?

Mr. MEREDITH. Really there is no difficulty in the admission as much as there is in the transportation to get them there. It is a long way; and again, the veteran is leaving home and oftentimes his family has been the only support, however much or little that might be. So, it is very difficult for them to leave and go great distances.

Mr. STEINBERG. Obed?

Mr. FERNANDEZ. Our working relationship with psychology and psychiatry services at the Veterans' Administration in Fresno is, I think, enhanced by the fact that there is a Vietnam veteran on staff in the mental hygiene clinic. Because of that, I think we are able to get people into our small medical center for substance abuse and alcohol problems and get some assistance in getting them into Menlo Park if that is required.

Mr. STEINBERG. So, you don't feel you are having a problem with the need for any formal adjudication of service connection in order to get a priority for inpatient or outpatient treatment?

Mr. FERNANDEZ. There, of course, are some logistical problems sometimes that come up; but more often that not, we are always able to get the help for our veterans in our particular center.

Mr. STEINBERG. Harry?

Mr. DOUGHTY. I think when a vet is formally adjudicated as having PTSD, then there is some compensation that may be involved; and I would suspect that many of us would be surprised once veterans are diagnosed and treated for PTSD, compensation and claims are not really issues.

I would rather that we treat the veteran for his presenting problem; and if he decides to file a claim, that could happen after the treatment process.

Mr. STEINBERG. That is one of the purposes actually of the provision, that is, to try to let treatment take place in the most timely and efficacious manner without the veteran having to go through a long adjudication process in order perhaps—for example, in Togus—to get the priority necessary to get treatment in an inpatient mode if that is what is called for.

So, that is one of the things that the committee was striving to do when it approved this provision.

How effectively do you believe the VA is treating the substance abuse disabilities of Vietnam veterans who are also suffering from PTSD? Please try to be brief, and Obed, we will start with you.

Mr. FERNANDEZ. The question again, please?

Mr. STEINBERG. How effectively is the VA doing in treating veterans with PTSD who also have substance abuse problems?

Mr. FERNANDEZ. I think that our particular veterans' hospital is doing a pretty good job of treating PTSD because, like I said, some of their staff are Vietnam veterans; and they are quite sensitive to those needs.

Mr. STEINBERG. So, it is an individual matter?

Mr. FERNANDEZ. Yes.

Mr. Steinberg. Would each of you concur in that, that some places are quite good at that and perhaps some places may not have individuals who are as well suited?

Mr. Meredith. If I may add, I really kind of concur with Obed. Basically, we have the same situation. We have a counselor who is a Vietnam veteran treating alcohol patients at the VA, and the care that I believe they are receiving is quite good.

Mr. Comeau. There is a comment I would like to make in relation to that.

Mr. Steinberg. Sure.

Mr. Comeau. It has to do more with the problems that the veterans have in accepting that perhaps they have a substance abuse problem along with PTSD. That is really a severe barrier to effective treatment.

We have worked as closely as we can with the alcohol treatment facility, but we still need to get a better approach—a better therapeutic approach—that combines both PTSD treatment and alcohol treatment to be really effective and to be acceptable to the veterans involved.

Mr. Steinberg. Harry, do you have anything you want to add? Let me ask you the next question because I know that this is an area where you have some knowledge. Could you describe what you consider to be the adequacy of training that you and your staff have been provided to deal with the problems of veterans suffering both from PTSD and substance abuse?

I know you have particular skill in that area, so you might want to outline that briefly; but then also note what you believe generally is the case in terms of vet center staff and the adequacy of their training to deal with veterans with this multiple problem.

Mr. Doughty. I think it takes a certain type of personality to work with substance abusers. Certainly, if you have a degree and training in that area, it would certainly compliment what you are trying to do.

I feel that the readjustment counseling service program has always, since 1980, attempted to identify and provide proper training in the area of substance and alcohol abuse. However, again, with the transitional stage of the program, many of our counselors do not have the background—such as I—with a degree in substance and alcohol abuse; but I think we do have enough expertise to identify those problems and make appropriate referrals.

Mr. Steinberg. Unless you have an urgent need to add something on this, I am going to suggest, as the chairman did earlier, that if you want to supplement on this particular point on the training of vet center staff to deal with those multiple problems, that you give us something in writing for the record.

We will be submitting some written questions to you, and we would ask you to communicate those directly back to the committee by July 22.

Finally, if each of you would like to comment very briefly on any suggestions that you have for methods by which the VA should be reaching out more to Vietnam and other war veterans who have PTSD but are not receiving mental health services? I am sure you are aware of the report in the VES study by the Centers for Disease Control that a very high proportion of veterans who they found had suffered incidents of PTSD had received no treatment whatsoever.

So, Bob, we will start with you, and I will ask you to be very brief, if you have suggestions for what the VA can do more effectively to reach out to those veterans with PTSD.

Mr. Comeau. One of the mandated components of the vet center has been outreach. One of the problems for vet center team leaders in the field—and I speak strictly for myself in this situation—is that we have to have some balance between outreach and working with actual clients in therapy.

I submit that we can be either predominantly an outreach operation, going out and reaching out to veterans in the community; or we can be predominantly a therapeutic operation, providing therapy to these veterans.

One of the major problems is that, when you do outreach, you set up or you establish an expectation. I think it is very important for the committee to hear that from a team leader, that when you establish an expectation that a veteran will receive help, he will actually receive treatment; it is far worse in my opinion to set up that expectation and not follow through than it is to ever outreach him at all.

That is one of the things I have kept very, very carefully in mind when I have worked at the Portland Vet Center. I do not offer what I cannot deliver.

Mr. Steinberg. If we enact this new provision that we referred to in establishing that sort of priority, once a diagnosis is made, you may have less of a problem in that regard in the future, if the resources follow what the law intends.

Mr. Comeau. Only, sir, if the resources do follow it.

Mr. Steinberg. Right. Would each of you like to comment briefly, please?

Mr. Meredith. Yes. Basically, I can concur with Bob because, once we make a commitment to somebody in Jackson, WY, if I can't deliver that service—which is very possible in the winter—he is going to be far worse off than if I had originally not gone at all.

So, I think that the resources must be there. Yes.

Mr. Fernandez. I would also concur with the statements of these gentlemen and would like to add that when you set up that expectation, it is based on the trust factor, which is something that PTSD veterans are suffering from. At that point, it is extremely critical that we deliver; and with that, I think it is understood.

Mr. Steinberg. Harry, do you concur?

Mr. Doughty. Yes, I do, and very briefly if I may, I am very concerned about the figure of 19 percent PTSD among black veterans; and I think it is very important that we understand why that may be identified in research but not seen in actual treatment. If I may, I will submit some of my thoughts in writing.

Mr. Steinberg. Yes, we would like that very much. That is one of the things we intend to pursue with you in writing as well as with the Veterans' Administration later.

[Subsequently, Mr. Doughty furnished the information which appears on p. 577.]

Mr. Steinberg. Let me, if I may have one more second, Mr. Chairman, just ask each of you to provide us with a written statement of your experience, your training, and then your tenure in the vet center program and where you have served and where you are currently serving. Thank you.

[This information is furnished with the questions and responses in the appendix.]

Chairman Cranston. I want to thank you all very much. I deeply appreciate your dedication to this work and the fine work you are doing, as others are at other vet centers; and thank you all for coming and sharing your insights with us.

Mr. Comeau. Thank you, Mr. Chairman.

Mr. Fernandez. Thank you very much.

Mr. Meredith. Thank you very much.

Mr. Doughty. Thank you very much.

Chairman Cranston. The next panel consists of representatives of the VA: Dr. John Gronvall, Chief Medical Director, who is accompanied by Dr. Paul Errera, Director of Mental Health and Behavioral Sciences Service; Dr. Richard J. Greene, Assistant Chief Medical Director for Research and Development; Dr. Larry Lehmann, Associate Director for Psychiatry; Dr. Art Blank, Director, Readjustment Counseling Service, Department of Medicine and Surgery; and Mr. Grady Horton, Deputy Chief Benefits Director for Program Management, Veterans' Administration.

I appreciate your presence, and I appreciate your helpfulness. I want to apologize for the fact that I am going to be able to listen to your opening statement, and then I am going to have to leave.

Jon Steinberg will carry on, but I will not have the opportunity to hear from the representatives of the various veterans' groups that are on the final panel; but I assure you that I will be aware of your testimony. I will take a look at it, and we will be considering your recommendations.

I thank all the people who have been present today, whether testifying or not, for your concerns; and we will be doing our best to figure out how we can respond to your suggestions and do more to deal with this problem. Thank you very much. Now, Dr. Gronvall?

STATEMENT OF DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. PAUL ERRERA, DIRECTOR, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; DR. RICHARD J. GREENE, ASSISTANT CHIEF MEDICAL DIRECTOR FOR RESEARCH AND DEVELOPMENT; DR. LARRY S. LEHMANN, ASSOCIATE DIRECTOR FOR PSYCHIATRY; DR. ARTHUR S. BLANK, DIRECTOR, READJUSTMENT COUNSELING SERVICE; AND GRADY HORTON, DEPUTY CHIEF BENEFITS DIRECTOR FOR PROGRAM MANAGEMENT

Dr. Gronvall. Thank you very much, Mr. Chairman. I can be very brief in summarizing. We submitted a long and fairly detailed statement for the record; but in a few minutes I would like to point out that the formal establishment of a specific focus on PTSD in the Veterans' Administration goes back to 1980.

That was the year in which our vet centers began to open. That was also, of course, the year in which the diagnosis PTSD was first given official recognition. During that period since 1980, I think there is clear evidence that VA clinicians and scientists have established status as national leaders in the field.

There has been plenty of evidence presented here today that PTSD has a wide variety of manifestations, severity, clinical course; and the treatment that we use is adjusted to the individual needs of the individual veteran who has had the diagnosis. Counseling, psychotherapy, and group sessions, of course, form the backbone; but our detailed statement describes other aspects of treatment.

I think it is particularly important to point out the importance of family counseling, spouse counseling, particularly in the chronic and recurrent cases. We do have several specific aspects of the department through which we provide care for PTSD. Most visible, of course, is our national network of the 188 vet centers, and these centers provide group, individual, and family counseling, and psychotherapy.

The success of the vet center program, we think, is heavily influenced by the fact that about 60 percent of the providers in the vet centers are Vietnam theater veterans; another 25 percent of them are Vietnam era veterans.

We have experienced improved working relationships between the vet centers and our medical centers, and the number of Vietnam veterans referred in both directions has increased remarkably. We see veterans referred from medical centers to vet centers and veterans referred from vet centers back to medical centers for care.

Then, for veterans, of course, who live a long distance from a vet center, we operate the fee contract program.

In addition to our vet centers, we do have the special PTSD treatment units in a number of our medical centers. At the present time, of the 27 medical districts that we have across the country, some 20 of those have a recognized PTSD treatment program in one of the medical center units; and a number of others are in the developmental stage.

Our experience, of course, is that the need and demand for PTSD treatment has not leveled off and will continue; so we continue to make forward plans. I do want to pay special thanks to Dr. Friedman and the other members of the special committee, who have already testified. There has been ample evidence today that their annual reports and the leadership they have brought to bear on the issue has been very helpful.

Just a closing, brief comment on both research and education. In April 1988, our special committee's report summarized VA research on PTSD and showed a significant increased in the amount of PTSD research, supported in one way or another, either at medical centers or by specific central office funding. Our detailed statement elaborates.

PTSD education has had national, regional, and local focus beginning about in 1985. We have carried out our educational programs through the assistance of our regional medical education centers [RMEC's]. In the most recent year, 1987, there were nine formal educational programs carried out under the direction of our education centers; two of these were national.

Our continuing education field units, also during 1987, carried out some 42 PTSD training programs with about 3,000 participants.

It was commented earlier that we are working on plans for at least three additional major educational projects. One of these will be a series of videotape teleconferences which will be carried out in every region.

Again, in closing, Mr. Chairman, I would call attention to accomplishments of dozens, and in fact hundreds, of individual professionals throughout our entire system who have made special contributions, not only in the VA but far beyond the VA in helping in the recognition of this condition, which of course has applicability not only among veterans but among other members of the general public as well.

We would, of course, be pleased to answer any questions; and it is a pleasure to be here. Thank you.

[The prepared statement of Dr. Gronvall appears on p. 404.]

Chairman CRANSTON. Thank you very much. As we told you, since I have to leave, Jon Steinberg will ask you the questions I was going to ask.

I would like to ask the representatives of the seven veterans' organizations, who are scheduled to testify, to stand for one moment and let me put one question to you. I have to leave now; I have an appointment with the FBI that I cannot break and then some other things that I have to do.

I know you have been waiting through the morning; so I want to give you a choice. You can either testify after we have gone through Dr. Gronvall and the VA's testimony, with Jon Steinberg asking the questions that I would have asked; and I assure you that I will be aware of your responses. Or we could reschedule a hearing some time soon—I don't know when—not next week—where you could each have a brief opportunity then to testify with myself or other members of the committee present.

So, it is up to you. Would you rather go ahead, since you have been waiting today, and testify with Jon Steinberg? Or would you rather wait for another hearing?

[Whereupon, the speakers responded in favor of testifying at the end of the hearing.]

Chairman CRANSTON. Since the majority prefers to go now, I think that is the way we should do that. Thank you very much. I apologize for the fact that I have to leave, but I do. I have been here since 9:30 a.m.

I have been informed that Mr. David Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans, has to leave at this time. Without objection I would like to insert his prepared statement in the record.

Thank you all very much. Jon, you carry on.

[The prepared statement of Mr. Gorman appears on p. 511.]

Mr. STEINBERG. Thank you very much for summarizing your testimony briefly, John, and we appreciate the patience of you and Art and Grady and Larry and Richard and Paul for being with us for such a long morning. I am afraid that the number of questions that we have will keep you with us quite a bit longer.

As you heard earlier today, the GAO through a survey of 14 VA medical centers has found that, in response to the RAM's incentives, changes were being made in the treatment program for veterans with PTSD, alcohol and drug dependencies, and other long-term psychiatric conditions.

In particular, the GAO reports that a number of programs shortened the length of stay in hopes of benefitting under the RAM when, in reality, the programs that made these changes actually lost money. Specifically, I believe the figures were that that was the case for seven of the eleven PTSD units, four of the nine long-term care psychiatric units and one of the three drug and alcohol units.

Are you surprised to hear those figures?

Dr. **Gronvall.** No, I am not surprised to see those kind of individual specific figures developed within the narrow definition of any particular program. Perhaps you want me to expand on why I say that? Or if you have a series of questions, I can go either way.

Mr. **Steinberg.** No; please explain your reasons.

Dr. **Gronvall.** Let me expand on the context then of my comments. The resource allocation model, of course, is a systemwide application basically of a procedure for identifying the amount of medical care delivered, using a DRG system that was developed outside the VA, but adapted to the VA, and then using that to influence the allocation to each medical center out of the fixed total appropriation that we receive.

In that context, whenever someone has taken the time—as GAO has done here and as other people have done in other areas—to dissect in very fine detail the specific relationship between the credit, so-called, for a given kind of medical or surgical problem, and the actual cost or the experience of individual medical centers, discrepancies arise going in both directions.

We, ourselves, have identified many areas in which the credit that is accrued significantly overestimates the actual cost to the medical center. We never adopted the resource allocation model with the idea that it was a perfectly refined vehicle for paying for each individual patient or each individual specific diagnosis.

In fact, fundamental to the model is the fact that individual diagnoses out of the thousands of recognized diagnoses are grouped into so-called diagnosis-related groups. So, within groups, there may be individual discrepancies.

Mr. **Steinberg.** But that is not, of course, what GAO is finding. It is not finding that the cost of care was greater actually for these individuals than the reimbursement formula. That is not what they are finding.

Dr. **Gronvall.** The GAO report—and they were good enough to review with us several days ago what their findings were before testifying; so we had a chance to discuss that with them—I think reports some very narrowly defined and specific instances where a specific change in length of stay changed the credit and, in turn, the reimbursement.

My only comment is that if you look individual diagnosis by diagnosis, you can find, I think, a good number of instances that have gone the other way, other instances that have gone this way. We still hold our medical center leadership accountable for running an entire program.

The GAO report itself comments on a number of program changes that they believe were stimulated by the RAM which were positive and for which the medical center was rewarded. On other occasions, of course, the General Accounting Office and others have soundly criticized the VA because we have had a longer length of stay than comparable community hospitals.

On balance, it appears to me that the resource allocation model has provided a powerful incentive to encourage each of our medical centers to look for ways to shorten lengths of stay; and I think, on balance, it has been good.

Just one other quick comment. In psychiatry, I think we have had a specific problem with the resource allocation model different from most other forms of medical or surgical care; and that is that I think it was everyone's observation that the DRG's applying to psychiatric diagnoses had not been nearly as well thought out by the people who originally developed the DRG model.

That is really the basis of a number of changes we have made year by year, and we have changed the RAM each year in regard to our psychiatry programs because of our own experience that the model was not as good a fit or reflection of actual work and cost of work in psychiatry as it was in other aspects of our program.

Again, all of that is the reason why I say that I am not surprised at those specific and narrowly defined findings. As the GAO said, we are relooking at the matter ourselves and looking for a better way to be sure that the reimbursement tool provides incentives for the kind of care that we want to deliver to veterans.

Mr. STEINBERG. Do these findings raise questions that you think—even though you have explained your view of them—require further examination in connection with the overall assessment that you are making of psychiatry under the RAM?

Dr. GRONVALL. Yes; absolutely.

Mr. STEINBERG. Let me just take 1 more minute then on this issue because it seems to me that your answer does beg one of the critical problems that we had when we first learned of this finding by the GAO.

That is, shouldn't medical centers be advised clearly that the RAM is going to work in a particular way, based on a particular decision they make, rather than being misled—as appeared to be the case here—into making programmatic changes in anticipation of RAM credit that was not forthcoming?

Dr. GRONVALL. The reason that has happened is that the data base that is used for resource allocation decisions is the most recent full year's experience of medical care delivered at a given medical center. What that means is that we go through a fiscal year, a medical center provides a certain amount of care; it takes us 4—or actually closer to 6—months after that year to ensure that we have scrubbed out all of the errors and problems and be sure we have an accurate report of all of the care given during that preceding year.

Those data then are used for the initiation of the budget allocation for the succeeding year. One of the problems has been that, any time we make a change in the resource allocation model, since the data we are using represent workload already accomplished, our medical centers regularly point out that that creates a problem if they, of their own volition, make changes in their patient care program with the intent that they get better credit in the RAM.

And then, we subsequently change the RAM as we apply it in a follow-on year. That, in essence, is viewed by the medical center as a retroactive application of new rules.

We have struggled with that and not found a satisfactory way around it because we have not thought it was wise to, in essence, make every decision and defer its implementation for 2 or 3 years to ensure that it was announced fully 2 years before it took effect because a large number of the refinements we have made, I think, have been widely viewed to be beneficial and appropriate and more appropriately relate funding to workload.

So, we always try to make the point that major programmatic changes motivated only by a desire to get better or different credit under the RAM is not the most desirable management; and I think in most of our medical centers, as you talk to the people, that is clearly only one of the factors.

They understand the financial implications of program decisions, but that is not the only factor that is entered into the formula.

Mr. STEINBERG. But it is not supposed to be a "crap shoot"?

Dr. GRONVALL. Oh, absolutely not; and I think that the impact of the RAM on balance has been extremely healthy in that it has brought a very powerful overriding focus on the actual total amount of medical care given.

For example, prior to the time that we had the resource allocation model, there would be medical centers where there would be renovation projects going on; and the desire of the medical center was to close a whole wing of the hospital while it was being renovated since the lost workload was not seen as having any direct relationship to the medical center's budget.

I think all of that has changed and we, like the private sector of hospitals, have felt that it is beneficial to have a much more powerful focus on the actual quantity of care delivered.

Mr. STEINBERG. You are not differing that there needs to be a certain strong element of predictability?

Dr. GRONVALL. Oh, yes; from my perspective, the changes we have made in the RAM year by year, I do not view as radical or totally undermining the ability of medical centers to know what to do. I think they are really more properly viewed as fine tuning. They do produce changes in the reimbursement to medical centers, and I have that pointed out to me regularly.

Mr. STEINBERG. Do you intend to carry out any clinical evaluation to determine what the effects of the changes in these PTSD programs have been on the quality of care provided to veterans in those programs?

Dr. GRONVALL. At least I am not aware of any specific proposal to do that. I see that comment in the GAO report. We make evaluations of the overall impact of the RAM, I think, in a broader sense by working with task forces which are broadly representative of medical centers and bring a perspective of what the RAM is and then, in turn, make recommendations wherever they believe that the RAM for this kind of reason, as defined here, or some other reason is having an inappropriate, negative effect on some aspect of patient care.

Mr. Steinberg. May I ask Dr. Errera or Dr. Lehmann if they have any intention to recommend any such evaluations with respect to these GAO findings and the seven PTSD units in question?

Dr. Errera. I have the intention and hope that we will be doing evaluation studies even before the GAO study comes out focusing particularly on the treatment in these 14 centers. One of the reasons we were concerned about the present Center for Stress Recovery is that it did not do such evaluations which had been mandated as part of it's task. So, the answer is yes.

Mr. Steinberg. So, you do plan to carry out such an evaluation?

Dr. Errera. Once we get a new center established, my hope is that that will be a major focus. The other way we can do it—and we have been having discussions about this—is through the HSR&D [Health Systems Research and Development] existing network by putting in an application for that kind of a study. There has been a small working group talking about that.

Mr. Steinberg. All right. The GAO has brought to light some apparently disturbing changes in response to the RAM. For instance, the shortening of the length of stay at one substance abuse treatment program resulted in restricting admission to the program to patients with fewer complicating problems—according to the GAO, based on the information that it received from that particular medical center.

These sorts of findings certainly suggest that the VA may be upgrading efficiency by restricting treatment to veterans who are less ill.

Another disturbing response to the RAM found by the GAO is the implementation of changed diagnoses after the 3-day assessment period. If 60 percent of the initial diagnoses of PTSD are actually erroneous, as GAO's figures suggest, you have one type of problem. Alternatively, it seems more likely that the diagnoses are being changed simply to benefit under the RAM.

Our request to you is to please look into both of these types of changes, including the use of the 3-day assessment program generally, and report back to the committee as to the effect that you believe these changes are having on the quality of care in these programs.

Could you do that for us, please?

Dr. Gronvall. We will surely attempt to. I think that it is very hard to isolate out a single factor such as the resource allocation model and, with assurance, define an impact on the quality of a program, because, as I said, it is only one of the factors. But we have surely heard your request, and we will attempt to define that.

Mr. Steinberg. Very well, but specifically to look at the quality-of-care effect of the 3-day assessment period, on the one hand, and also of the substantial number of changed diagnoses, on the other hand. If those are misdiagnoses, that certainly is another problem that needs to be addressed outside of the RAM.

Dr. Gronvall. I should say that we have systemwide efforts to review, particularly through our Peer Review Program, MEDIPRO and the SERP programs, to monitor and review the establishment of diagnoses to try to ensure that gaming doesn't occur.

Like any large system operated by humans, we do have evidence that that occurs; but we have explicit review mechanisms in place to try to identify them, and we have done so and deal with it when it does occur.

Mr. STEINBERG. Thank you. RTI data from the preliminary report released on August 15 of last year indicate that half of the male Vietnam theater veterans currently experiencing high levels of PTSD symptoms have never been seen by a mental health professional for their PTSD symptomatology and that 87 percent have not been seen recently by any health professional concerning their symptoms.

How do you explain this striking evidence apparently of a lack of effectiveness of VA outreach efforts to these veterans?

Dr. GRONVALL. The only comment I would make is that I would disagree with the inherent conclusion in your question that, because a certain number of veterans have never gone to anybody about a problem, that that represents a failure of this particular VA program. But I would like to turn to Dr. Blank, Dr. Errera, and Dr. Lehmann to comment on some of the reasons.

We heard some earlier testimony here today from the people working in the vet centers regarding some of the aspects of PTSD as a specific problem that, in fact, leads to a reticence of veterans to seek help from anyone, including the VA. So, that is the context of my comment, that it doesn't necessarily represent a failure.

Mr. STEINBERG. But they were particularly commenting on the fact that the resources are not available to treat greater numbers, and they were reluctant to do outreach to draw in larger numbers of veterans and then disappoint them, once they should come for treatment, if indeed the resources would not be there to do so.

Dr. GRONVALL. I was referring to the comment that spouses often come to describe the problems occurring in a family and that the veteran, in that case, for reasons caught up in the impact of PTSD on the individual, in fact, deliberately avoids or does not seek care. That was the earlier comment that I was referring to.

Mr. STEINBERG. Dr. Blank, would you like to comment on this question?

Dr. GRONVALL. Dr. Blank?

Dr. BLANK. I am in fact somewhat surprised by the RTI finding concerning the apparently rather low number of veterans with PTSD who have received help from any VA element. I would not have expected the percentage to be as low, particularly in light of the number of cases we think we have seen so far in both vet centers and medical facilities.

I think that this finding is something we are going to have to look at very carefully. One speculative comment I would offer is that there may be an element here having to do with the extensive geographical dispersion of the sample, which was surveyed by the RTI study.

It in fact is a highly dispersed sample, which is quite appropriate and felicitous from a scientific standpoint. It is such because the sample was drawn from a random selection of military records. There may be a contribution, therefore, to this finding from the geographical dispersion. Regardless of how many medical centers and vet centers we do have, we only cover a certain portion of the map; but that is merely speculation at this point, and I think it is something we have to look at very carefully.

Mr. STEINBERG. Of course, if the RTI figures of approximately 471,000 Vietnam theater veterans with current PTSD are at all accurate, then a finding that somewhat more than half of these veterans had never seen a mental health professional—at least in terms of the VA—would not be inconsistent with those data, given the data in your statement as to the numbers that you believe you have been seen in the vet centers and in your own facilities, which of course is not a complete census, as you point out.

Dr. BLANK. That is right.

Mr. STEINBERG. Dr. Errera, did you have anything you wanted to add to this?

Dr. ERRERA. Yes. I think there are two questions, as you pointed out. One is resource availability, and let me leave that one aside; the other one, I think, is even more intriguing, which is that I think we have a health delivery system that is set up for the middle classes and the upper middle classes, people who are expected to go to a place where health care is provided at a certain time.

This is fine for those groups; but if you are trying to address the needs of the poor, the aged, the homeless, the alienated—and the PTSD group that we are talking about fits into some of these categories—our present system doesn't optimally address their needs, which means you would have to readdress or restructure how our Nation's health delivery systems provide help, not just the VA.

This is something people talked about in the 1960's, as you will remember, the question of a community health storefront. This is not a vet center; this is a hospital extending itself, reaching out to the community to these particular segments of the population. It is a very complicated, fascinating challenge that I think some day we will have to address.

Dr. GRONVALL. And Mr. Steinberg, if I may, the only real intent of my original comment was that I think in a number of places there have been some pretty vigorous efforts to try to break through that kind of social or structural problem in this country; and in spite of the best efforts to date at least, I think all such studies identify that there remains a residual number—unfortunately a large number of people—who suffer from a number of different medical and psychological problems who, for some reason caught up in their own interpretation of what is going on, in fact avoid care.

I don't think anybody has been able to find a way to break through that. I would surely agree with you that that number pointed out in the RTI study would be consistent with the experience we have had, both in our hospitals and vet centers, in relation to the proportion that have come to us to seek care.

Mr. STEINBERG. The interesting part of it is that they are not asking only about coming to you; they are asking as well about seeking care at any point in the mental health system.

Dr. GRONVALL. Yes.

Mr. STEINBERG. Following up on what you just said, Dr. Gronvall, could you submit to us any studies or citations to studies, if you don't have them available, which would substantiate that point that you just made, that generally in terms of psychiatric care there are a substantial number of individuals who have problems and who might benefit from care and who do not seek it?

Dr. **Gronvall.** Yes, I surely will.

Mr. **Steinberg.** All right. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

Many individuals have psychiatric problems which potentially could be alleviated through counseling or psychotherapy, but for various reasons they do not seek it. Some published articles which address this issue are the following:

"Utilization of Health and Mental Health Services", Sam Shapiro, et al. Archives of General Psychiatry, 41: 971-978, 1984.

"Factors Affecting the Utilization of Specialty and General Medical Mental Health Services", Philip Leaf, et al. Medical Care, 26: 9-26, 1988.

"Who Talks to Physicians About Mental Health and Substance Abuse Problems?", Daniel Ford, Journal of General Internal Medicine, 3: 363-369, 1988.

Mr. **Steinberg.** The Paralyzed Veterans of America, on page 10 of their testimony, recommends that the VA's Mental Health and Behavioral Sciences Service make a thorough review of the Agency's PTSD inpatient units in order to assess whether additional resources should be allocated to individual units and whether resources should be transferred to VA medical centers wishing to establish new treatment programs.

What are your views on whether such assessments of existing PTSD inpatient units needs for additional resources and of the need for additional PTSD units should be undertaken?

Dr. **Gronvall.** I surely think that having a clear assessment of need and using that in regard to planning is always valuable. I think it would be appropriate to ask Dr. Errera to comment on the way in which that is being done in relation to the PTSD units that are in the planning or developmental stage.

Mr. **Steinberg.** Dr. Errera, do you wish to comment on that, or are you thinking?

Dr. **Errera.** I am thinking. [Laughter.]

Mr. **Steinberg.** All right. If you would like us to give you a moment or two more, we will address another question and come back to you.

Dr. **Errera.** No. Dr. Lehmann, anything you would like to say?

Dr. **Lehmann.** Yes. We are in the process, as several people have mentioned, of developing program guides that will carry information about some general aspects of treatment for PTSD that will be helpful both for people who are planning programs, as well as helping people to maintain certain standards in carrying out those programs.

The program guides will address treatment both in general psychiatry inpatient and outpatient units, as well as the activities of the specialized inpatient units.

Mr. **Steinberg.** That is not responsive, if I may, to the point that is being made here, which is that there is a need for an assessment of the adequacy of resources at the existing 14 or 16—I am confused somewhat from your testimony as to how many there actually are—specialized units, and of an assessment of your other medical centers to determine whether there is a need for such further specialized units at those centers; and, concurrently, whether or not there should be a moving around of resources among the existing units.

I don't think program guides are going to address the need for that kind of an evaluation.

Dr. **Lehmann**. For that kind of evaluation, no. Program guides address some of the things one has to do to create the programs. What you are asking is: Is there an assessment of need that would predate the establishment of programs?

That is one of the things that I think the special committee has attempted to do in their third annual report in giving some information on demographics of Vietnam veterans and incidence of PTSD and in passing that information on to the regional directors, as they commented earlier they have done.

We also know that there are plans for the development of other PTSD units that do meet some of the perceived needs—that have been identified geographically for the development of some inpatient units, particularly in the middle part of the country, as mentioned earlier.

Mr. **Steinberg**. But you do not see a need for the kind of comprehensive evaluation described in the PVA's testimony, even in the face of the data which was revealed this morning by the RTI in their testimony? Dr. Errera, we now welcome your answer to the question.

Dr. **Errera**. You are addressing resource availability, Mr. Steinberg; and I think we can go back to your question: Was I surprised, for example, by the finding that if you shorten length of stay, you lose money? I would have said: No, I wasn't surprised, because given the funding—and this is something that Dr. Gronvall alluded to in the initial funding of the DRG's—given the fact that PTSD is funded as one of the lowest paying DRGs, in a long-term setting such as the 13 or 14 programs, you earn $39 a day during your 45-day period.

This is the time period when you are funded by the DRG. You know what $39 pays for. Once there is an outlier rate, that goes up to $90; so, relatively you are earning more money. But I can't conceive of trying to move money around; I mean, it is a question of: Am I going to take away from people getting only $39 to begin with? So, we have a restricted fiscal pool; within that restricted fiscal pool, I would say——

Mr. **Steinberg**. If there is not a need to look at whether or not money should be moved around within the 14 or 16 specialized centers, is there a need to make an assessment of the rest of the system, in light of the data that were testified about this morning, in terms of whether or not further specialized inpatient units are needed?

Dr. **Errera**. Or the further treatment capability of one kind or another?

Mr. **Steinberg**. Whether that be by treatment teams, outpatient units, generalized, specialized, or whatever, is there a need in view of these findings for that kind of an assessment?

Dr. **Errera**. That is an interesting question. Yes.

Mr. **Steinberg**. Dr. Gronvall, do you have an interesting answer? [Laughter.]

Mr. **Steinberg**. The burden of the question—and we will be talking about it in some later questions—is: Are we about to pay $9.3 million for this study, have a hearing about those data, file the report away, and go back to business as usual? Or is something going to happen with respect to what those findings suggest?

Dr. GRONVALL. I think, Mr. Steinberg, the reason that we are sitting here kind of wondering how to respond is that we have heard the data presented today. We had an oral report that I got through third hand people yesterday as to what the findings were. By the request of the committee, RTI has presented this report here today.

I was sitting trying to read it while I was listening to other people testify. I think that to then pose a question and say, in light of these remarkable findings, aren't you going to do this, do that, do anything specific, really is not the most appropriate way to deal with what I think is a very important finding.

The chairman's opening statement called those data nothing short of shocking. This is very important, new information, gives a new dimension to our understanding of the problem. I think that for us to then give it appropriate attention requires a lot more than just immediately saying: Well, of course, what we want to do then is assess all of the existing programs and talk about moving money to some other things.

I think we haven't got the basic report. We have read the summary that they have prepared as testimony. I think it is essential to have the actual report and give our professional staff the chance to review it. I am sure that we will turn to our special committee to ask their help in what the impact, not only of that specific number in the report, but all of the other implications in that report, are on VA programs.

I think that takes time. I know we are always guilty of taking more time than we should to jump from an observation to a set of general plans; but since everything we do has all kinds of implications for other programs, facilities, budgetary decisions, et cetera, et cetera, I think that some time really is required to take a new set of observations that may significantly change our understanding of what the dimension of this program ought to be or its geographic dispersal, what the mix of efforts of outreach for example by ethnic group because that is a remarkable finding in the report.

So, I think it is all the weight of that kind of deliberation that has to go on that leads me, at least, to feel like I don't want to just quickly jump and say: Oh, yes, that is a wonderful idea; let's quickly assess this and move some money to some other place.

I have trivialized the question by the way I described it; I realize that. Clearly, we need to assess what we are doing in light of the new evidence, make plans to better meet the need as it has been identified by the results of a major national study.

Mr. STEINBERG. Do you have any reason to believe that the findings made by RTI and the methodology employed by RTI are defective in any way?

Dr. GRONVALL. No, I sure have none whatsoever; and based on the very close working relationship that the Veterans' Administration has had with the study—and we have had a team of technical experts, of course, that have been involved in the study design and much of the escalation of the budget of the study and the lengthening of the timetable—resulted from the VA specifically wanting to ensure that the final output of the study was valid and could be used.

Mr. STEINBERG. You are sounding like you are saying you would be disowning your own child, were you to do that, that is, disown the result of that study.

Dr. GRONVALL. That is a reasonable analogy——

[Laughter.]

Mr. STEINBERG. I apologize for interrupting you.

Dr. GRONVALL. I think this is a child we bought rather than gave birth to. [Laughter.]

And perhaps there is a little more wiggle room there; I don't know. In any event, we clearly will give major attention to the study. And as I say, there is no reason that I am aware of—and I have asked that question very specifically—why we do not think that is a credible and valid finding.

In fact, as I have talked with our staff about some kind of earlier "guestimates" or judgments that they have made, they think this is consistent with that.

Mr. STEINBERG. Could we ask you, if you would, please—and let us know what timetable would seem reasonable for this—to have your experts in the area of mental health services and in the area of research, look at the methodology questions that we discussed earlier this morning as between the VES and the RTI studies and give us the benefit of any enlightenment that you could on that?

Dr. GRONVALL. Yes, we surely will do that. I think we should followup and supply to you for the record comments on that, as well as an expected timetable for us to review the report and to work on national plans that would derive from the impact of the report.

Mr. STEINBERG. That would be very helpful. Can I get a timetable as to when we might get a timetable? What would be a reasonable timeframe in which you might be able to create a timetable?

Dr. GRONVALL. I would expect that that maybe would take us 2 or 3 lweeks to lay out a kind of order of magnitude of the timetable.

Mr. STEINBERG. Could we set August 1 then as the date by which you would get back to the committee with respect to a timetable? And then, if by that time, you have some preliminary assessments of this methodology question that we discussed at some length earlier—

Dr. GRONVALL. Yes. That would be fine.

Mr. STEINBERG. Thank you very much. Mr. Horton, the PVA, also on page 12 of its testimony, expressed its concern regarding, as it puts it, "reports of dramatic inconsistencies and approval rates and disability rates granted for PTSD from one regional office to another."

From reading your testimony this morning, it appears that you do not believe that it is a problem in general for there to be substantial variations among DVB regional offices in allowance rates for PTSD claims. Is that a correct reading of your testimony?

Mr. HORTON. I am not sure that I would say there is not a problem, but I would say that there is not a systematic problem. You have to understand that the rating process in PTSD requires two elements in order for you to be service connected. First, there must be the diagnosis of PTSD; and second, there must be an identified stressor.

We do studies of the differences. When anybody is 15 percent above or below the average, we have asked the station to do an analysis, and we have done some analyses in the central office of what causes those differences.

Mr. STEINBERG. You say this is just on PTSD or other specific areas as well?

Mr. HORTON. No, just in PTSD. Actually, Mr. Steinberg, we can't identify in our system disabilities other than PTSD, agent orange, prisoners of war, asbestos, AIDS, and radiation cases which are in our system. But once those PTSD cases vary from the norm by 15 percent, we analyze them.

There are a number of reasons, including some disallowances that should not have been made and so forth; but the overwhelming major reason is the lack of the PTSD diagnosis. If you in general get a PTSD diagnosis and we find the stressor, you can be fairly well assured of getting service connection for PTSD.

Mr. STEINBERG. You mean no credible mental health professional in those cases has indeed diagnosed the veteran as having PTSD. Is that what you mean by a lack of diagnosis?

Mr. HORTON. I should, I guess, defer to somebody else about credible psychiatric diagnosis; but what we are talking about is that you will have somebody with a claimed PTSD disability that comes back with a different diagnosis, or substance abuse without PTSD—this sort of thing.

That is, in general, an absolute bar to our granting service connection at that time. Now, that doesn't mean that through the appeal process and other developments, that eventually service connection might come about.

Mr. STEINBERG. You are saying that the single greatest factor to explain the regional variations in allowance rates for PTSD claims is that, in certain regions, there is frequently present in the claims a lack of a PTSD diagnosis. Is that correct?

Mr. HORTON. Yes, sir.

Mr. STEINBERG. Now, that is somewhat different from your testimony which points to "demographic and cultural mores of the veteran population served by the regional office."

Mr. HORTON. We think that sort of thing exists as well. You know, there are a number of factors, which I will be glad to give you for the record, of what we are finding when we do those studies. But the central, overwhelming reason that you don't get service connection in these cases is the lack of a diagnosis.

[Subsequently, the Veterans' Administration furnished the following information:]

MAJOR REASONS FOR DENIAL OF PTSD CLAIMS

Based on written and oral reports from the regional offices, it appears that the major reasons for denying PTSD claims are the lack of any diagnosis of a psychiatric condition and a diagnosis of a psychiatric condition other than PTSD. Rating boards cannot grant service connection for PTSD unless a physician, based on a thorough psychiatric examination, gives a diagnosis of PTSD.

Claims for service connection or for an increased evaluation must also be denied if the veteran fails to report for a scheduled VA examination. A recent report from the Los Angeles Regional Office indicated that this is a serious problem in their jurisdiction.

In addition to a medical diagnosis, in order to grant service connection a rating board needs supportive evidence sufficient to permit a reasonable conclusion that the stressful event occurred in military service as alleged. DVB Circular 21-86-10 provides guidance as to the type of evidence required and instructs the regional office concerning the development for such evidence. If no or insufficient supportive evidence of the reported stressor can be found, the rating board has no option but to deny service connection.

Mr. STEINBERG. Then, why should that vary by regional offices? Is there something about the cadre of mental health professionals in that particular region which makes it harder for the veteran to gain such a diagnosis? Is that what you are suggesting might be the underlying cause?

Mr. HORTON. I think the Special Committee has found that to be one of the problems that they want to address with the training program, and we are addressing those.

Mr. STEINBERG. Dr. Errera, do you have any comment on this issue? I think it is your profession that is somewhat being implicated.

Dr. ERRERA. I think Mr. Horton is on target. I think there is a marked fluctuation/variation in the way C&P exams are done. I think this is not just in psychiatry. I think that the status of the C&P exam in medical centers, having remembered what it was like, is not at the top of the heap. It is not the thing we value most and have most able clinicians do, as it should be.

This is reflected then in the caliber of what Mr. Horton's people have to work with. There are times when we hire a community physician, let's say in psychiatry at $20 for half-an-hour, to come and do C&P exams. We get what we pay for.

Mr. HORTON. One of the other factors is, of course, the type of claim that would be referred, that is, the way the claims come in. I think the vet centers have a play in that, that people who have access to vet centers perhaps file more claims, better claims.

There are geographic and other factors involved in this, other than the diagnosis; and I certainly don't want to put it all on the diagnosis. In fact, that may be the reason you get better diagnoses in some cases, or more favorable diagnoses.

Mr. STEINBERG. Now, you have testified, I believe, that historically—and I don't know for how long—if you found a variation of 15 percent in the allowance rate—I guess that it is 15 percent under the average—then you have taken a special look at those regional offices. Is that correct?

Mr. HORTON. Yes, sir, above and below.

Mr. STEINBERG. Above and below. How long has that been in effect?

Mr. HORTON. In the past year.

Mr. STEINBERG. And do you intend to continue that?

Mr. HORTON. Yes, sir.

Mr. STEINBERG. Could we ask that if you anticipated discontinuing it, that you advise the committee of that?

Mr. HORTON. Certainly.

Mr. STEINBERG. And could we further ask that you provide us on a quarterly basis, if that would be reasonable for the next year at least, the results of those assessments and the particular stations that were looked at as being above or below? Would that be reasonable to expect?

Mr. HORTON. I would be happy to.

Dr. **Errera.** Mr. Steinberg?

Mr. **Steinberg.** Yes, Dr. Errera?

Dr. **Errera.** The other side of my comment is that we have been addressing this collaboratively. Dr. Lehmann and the people from Grady Horton's staff have developed guidelines; there have been educational efforts to upgrade both the physicians and the reviewers.

Mr. **Steinberg.** Yes, I think we will probably come back to that somewhat later. We are aware of the training guide that is in preparation.

Also, Mr. Horton, according to Dr. Friedman's testimony this morning—his prepared testimony—there is a high rate of allowance at the Board of Veterans' Appeals for PTSD cases, as compared to the normal BVA allowance rate of approximately 13 percent. Are you aware of whether or not that is correct?

Mr. **Horton.** I would disagree with that. I checked the figures just before I came over here, and the figures we were given were 15 percent, a 2-percent difference; but I wouldn't consider it significant.

Mr. **Steinberg.** I think we would all have to agree with that. And I would have to ask Dr. Friedman, and I don't know if he or any other members of the special committee are still here or not.

Dr. Friedman we would ask you, not at this point, to share with us the basis for that observation in your testimony in writing, if you would, that there is a substantially higher allowance rate.

[Subsequently, Dr. Friedman furnished the information which appears on p. 295.]

Mr. **Steinberg.** Let me ask you this question hypothetically then. If there were a substantial disparity in that respect, do you believe that it would be appropriate for you, in consultation with the BVA, to issue guidance to your regional office adjudicators as to how BVA was deciding these cases so that we would avoid the 400 or more day delay that an individual has to experience before they could get an allowance before the BVA? Do you feel that is part of your responsibility?

Mr. **Horton.** Responding hypothetically, if that were true, of course, one of the things that I think is unique among PTSD ratings is that the process itself and the evidence itself is often complicated. But unique among our claims, anyway, of people who are making claims that are typically not found in the service medical records, such as radiation and agent orange.

These cases are relatively simple in concept to rate. If you have the PTSD diagnosis and you have the stressor, you will be service connected for that.

Then, the only issue is regarding the degree of service connection. So, I would be very surprised if we had a great deal of overturns by the Board of Veterans' Appeals in these cases.

Mr. **Steinberg.** On the second issue, what evidence is satisfactory with respect to the stressor?

Mr. **Horton.** We are very liberal on that, at least our instructions are; and that may be the type of case that the Board of Veterans' Appeals overturns us on: A combat infantryman's badge, a Purple Heart, evidence from the DD–214 that he was in a combat area.

The medical documentation of the stressor is perhaps the more difficult part of it. In the medical exam, the physician must indicate the stressor that caused the condition, or the stressors—more than one. I don't think that that is a major problem for veterans to overcome.

Mr. STEINBERG. So, if the veteran can demonstrate that he was in a combat situation in which it is reasonably likely that the situation that was outlined on the basis of which the diagnosis was made, in terms of there being a stressor present, was in fact present, then that satisfies the second requirement. Is that your testimony?

Mr. HORTON. Assuming that the medical report showed that the stressor was in a combat zone, and we have an indication he was in combat, that meets the requirement.

Mr. STEINBERG. Now, you say you have to have an indication he was in combat. That wasn't my question because that gets into the question: What evidence does the veteran have to produce—a combat infantryman's badge?—that he was in a unit that was in combat during that period?

Mr. HORTON. That is sufficient.

Mr. STEINBERG. Would you provide to us for the record the instructions that you have issued on this particular question?

Mr. HORTON. I would be happy to.

Mr. STEINBERG. And comment specifically, in addition, on how those instructions indeed reflect the policy that you described to us this morning?

Mr. HORTON. I would be happy to.

[Subsequently, the Veterans' Administration furnished the information which appears p. 428.]

Mr. STEINBERG. And I think you earlier indicated, when you talked about the 15 percent practice that has been in existence for the last year, that you would provide us more information on how that has been carried out in terms of your regional office reviews, that is, the review of regional office adjudications where there is a variation, if you would provide that for the record as well.

And also provide us for the record, please, the data for each regional office showing the number of claims for compensation based on PTSD, the number of awards of compensation based on such claims, and the percentage ratings and how those break down? And if you can give us those data for fiscal years 1984 through 1987 and the first half of 1988, if those data are available—are such data available?

Mr. HORTON. Yes, they are; and we can provide those to you very readily. I would add only one caveat. Our system does not break down sufficiently to show the grant or denial of service connection as opposed to the grant of an increase.

So, when we show a grant rate of 54 percent, that includes original grants; and it also includes claims for increase. Our system just won't break it down any further.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 432.]

Mr. STEINBERG. You have a problem setting that up prospectively?

Mr. **Horton**. Our system is just not set up to do that. The information you ask for, I believe, reasonably will give you what you are looking for.

Mr. **Steinberg**. You could not alter the computer program?

Mr. **Horton**. We could.

Mr. **Steinberg**. So that you could collect differences between increased ratings and new allowances? You could not do that?

Mr. **Horton**. We could, but we could not do that easily; and the system that we have now does not do that.

Mr. **Steinberg**. You could not do it easily prospectively. Is that correct?

Mr. **Horton**. We could do it. Anything can be done with computers easily if you put the resources to it.

Mr. **Steinberg**. Would you provide us with a response for the record as to what would be entailed in doing that on a prospective basis, and the cost that might be entailed in doing that?

Mr. **Horton**. I would be glad to.

[Subsequently, the Veterans' Administration furnished the following information:]

ESTIMATED PROGRAM COSTS FOR SIRS REDESIGN

The Special Issue Rating System (SIRS) is an on-line real time system that establishes or overlays a claim in the central system. There are no comparisons performed when a subsequent claim is made for an increase in benefits. In order for the system to capture the information requested, a total redesign and reprogram of the system would be required.

The modifications required to the computer system would be as follows:

(a) Develop a new database to store and retain the differences (data element) in the Central System SIRS Master Record.

(b) Develop system internal-external specifications (edits, error messages, etc.) required to compute the differences in the Regional Data Processing Centers (RDPC).

(c) Modify the Pending Issue File processing located at the RDPC to retain the current issue for comparison to the new issue.

(d) Design output report requirements to inform the users as to the status or changes in statue of initial versus subsequent claims.

Based on our experience with systems modification of this magnitude, we estimate that the development (documentation) and analysis activity and the programming (coding) effort would require over 6 months at an estimated cost of $100,000. These estimates are based on the general requirments presented.

The implementation date is contingent upon the priority assigned to the project relative to current resource commitments. It should also be noted that there are currently 30,903 PTSD cases in SIRS. These records would not contain the new data elements unless a subsequent claim is processed.

Mr. **Steinberg**. Let me ask you to comment on this statement, either Dr. Gronvall or Mr. Horton, Dr. Blank, Dr. Errera, or Dr. Lehmann; page 6 of Dr. Gronvall's testimony states that approximately 158,000 of the veterans seen by vet centers have been seen for PTSD diagnosable according to present standards.

On page 21 of the statement, it indicates that over 22,000 veterans receive disability compensation for PTSD. This suggests to us that either a large number of veterans are being seen in vet centers for PTSD and are being cured, or that those veterans are not in fact suffering from the disorder to a compensable degree, or that they are simply not applying for compensation, or that they are having significant problems with receiving an adjudication as of service connection.

Could you make any comments on any of those observations?

Mr. HORTON. I, for one, was surprised at the vet centers having reluctance to send people in to make claims because it would in some way mess up the treatment process. We have been keeping records since 1980 for PTSD, and those claims are basically as I have stated them. We had something in the neighborhood of 50,000 claims, of which 22,000 are drawing benefits.

That data just has to speak for itself. I am sure from my own experience in the field that we probably have people with PTSD who are drawing compensation under other diagnoses, and they would not separate out under our system. We couldn't identify them specifically.

Mr. STEINBERG. Dr. Gronvall, could I ask whoever from DM&S might want to speculate on those comments? Dr. Blank?

Dr. BLANK. Yes. Could I ask you to repeat the possibilities?

Mr. STEINBERG. Our suppositions were that large numbers of veterans being seen in the vet centers for PTSD are being cured; or that they are not suffering from a disorder that is compensable; or they are not applying for compensation; or they are having significant problems in being adjudicated as service connected.

Dr. BLANK. I think the answers to the above are that there are a number of veterans who, even in some instances notwithstanding chronicity and considerable severity, do respond very well to treatment. There are, I think, a number of veterans with relatively mild conditions who are less than compensable, especially subclinical cases.

There are a number of veterans who are having difficulties with the adjudication process; and our experience is that there is a very significant number of veterans who, although they may have quite substantial PTSD, are not interested in compensation.

Mr. STEINBERG. May I just interrupt for a moment? Were you suggesting that, of the 158,000 described on page 6 of your testimony, some of those were subclinical?

Dr. BLANK. No. I am sorry; I misspoke. I meant to indicate that there are some veterans who would not meet diagnostic standards, at least from a DVB standpoint, perhaps at some point in time, whereas at another point they might. This is a condition which waxes and wanes significantly in a number of cases.

Mr. STEINBERG. Dr. Gronvall, we would like to ask you some questions following up on Dr. Friedman's testimony in his capacity as chairman of the special committee and think that we should keep in mind, as we approach those questions, the discussion we had earlier with respect to the RTI findings, which you are not disputing, and your testimony in your prepared testimony on page 10 that "the need and demand for PTSD treatment services in VA medical centers has not leveled off."

It seems to me that we can assume, in the absence of a dispute about the RTI findings, that we have somewhere in the vicinity of a half million Vietnam theater veterans who currently are suffering from PTSD and have probably some need for mental health care services.

And according to other RTI findings and CDC findings in the VES, many of them are apparently not receiving treatment.

So, with that background, unless you would like to contradict anything I said as an assumption, we can start with reference to page 6 of Dr. Friedman's statement where he notes that "the special committee believes that PTSD's unique etiological relationship to combat exposure should give PTSD very high priority by the VA in comparison with other programmatic requests." And he goes on to state that that priority does not exist.

Would you comment on both his statement about the need for priority and his statement about the existence of such priority, and indicate ways in which you believe that such relatively high priority has indeed been accorded by the department to PTSD, especially in terms of personnel and other resources being dedicated to treating veterans with PTSD?

And then, finally, any plans that you have for affording a higher priority to PTSD?

Dr. GRONVALL. That is a mouthful of a question, obviously.

Mr. STEINBERG. It reminds me of the questions that Senator Simpson used to ask. [Laughter.]

Dr. GRONVALL. I surely cannot take exception with the statement that any physical, psychological, or other condition, which is a derivative of war experience, either does have or must have high priority with the Veterans 'Administration. That is clearly what we were established to take care of.

Mr. STEINBERG. If there is no quarrel with that statement, the question is: Does it have such a priority?

Dr. GRONVALL. The eligibility statutes that we work under across the board in our medical care system, however, I think don't make it that clear in terms of one particular aspect which we are here discussing today—PTSD. And clearly, the individuals who devote their whole professional lives and efforts to any one particular area and where that area of disability is clearly related to military service, or combat service in this case, always feel that that ought to be the number one priority of the Veterans' Administration.

The problem we have as a whole system is sitting through a number of such sessions where the people assert that same very powerful and very understandable statement.

Mr. STEINBERG. What we are talking about here are conditions that your own diagnosticians find is related to service.

Dr. GRONVALL. Yes, of course. I think in this regard it is complicated by the fact that this is a newly recognized diagnosis. Now, maybe some would say that is stretching a point, to say that something formally recognized as long as 8 years ago ought to be well established and well accepted; but the fact is that it is a relatively new diagnosis.

I was not in the VA at that time, but the VA and the rest of the health community faced in 1980, in essence, a whole generation of professionals trained and in practice prior to the time this was even recognized. So, the educational efforts we have conducted and the other things that our statement addresses have been an attempt to catch up and establish widespread recognition of this condition.

I think further that we regularly have it pointed out to us that the priority, if priority is judged by investment of resources, the priority that not only the VA makes, but that the Nation as a whole makes with regard to the whole category of mental illness, is low compared to the incidence of mental illness an it is a problem that society faces.

And we regularly have it pointed out to us that some other kinds of conditions, particularly surgical conditions which may be extremely dramatic but very low in incidence, consume very large proportions of the health-care funding, not only in the VA but elsewhere.

So, my view would be that PTSD as a condition has had an uphill struggle officially in the VA, relatively recently recognized. Our recognition of it and our programs for it have been expanding. We have assigned additional staff and resources specifically for treatment of that condition.

I wouldn't try to make the case that the extent of the resource commitment exactly matches the extent of the problem; but I would have to say that for other reasons, I have just recently had a chance to review the past 10 years of data about the whole V health-care system.

Without getting into too much detail, during that time if you adjust our appropriation on the basis of medical care CPI, our funding has been level. During that time, we have significantly expanded the number of patients treated in our hospitals. We have significantly expanded the number of patients that we pay for in other hospitals.

We have opened new nursing homes and significantly increased the nursing home census; and we have amazingly expanded the extent of outpatient care, going from some 5 million visits a year to 20 million visits a year in 10 years. All of that has been accomplished with an appropriation that is level in terms of purchasing power.

That has been done by a whole set, I think, of very strong internal dynamics that put pressure on increased productivity and the accomplishment of new programs without new real resources, and that has come about by reallocation from existing or previously existing programs.

So, the expansion of the effort on vet centers has come about within that context. I think that the study that RTI has done and the identification of the prevalence of the problem from other studies, but particularly the RTI study, will provide powerful new evidence.

This hearing is a piece of that, in heightening the attention of the VA, I think, to the extent of the unmet need; and I have no doubt that the followup to this hearing will be an elevated level of attention to the needs of our treatment programs for PTSD.

Again, it will have to come at the expense of something else; and all of the information that we have about the upcoming year, 1989, is even more bleak than the past 10 years because a new statute has been passed that will obligate us to undertake something like $200 to $250 million of unfunded program commitments.

There are some actions yet that may occur that would change that. So, we are not looking at a year when——

Mr. STEINBERG. Are you talking about the recent law that was enacted?

Dr. GRONVALL. Yes.

Mr. STEINBERG. You used the term "obligate."

Dr. **Gronvall**. Part of the law is mandatory; a significant part of the law is mandatory.

Mr. **Steinberg**. Not $250 million.

Dr. **Gronvall**. Correct. That was why I put some weasel words on the thing; but I was giving the total bill for the whole law.

Mr. **Steinberg**. What is the amount that is mandatory?

Dr. **Gronvall**. I don't remember the exact breakdown of mandatory versus discretionary, and we have been having some meetings in the VA about the extent of the discretion on some of the components.

Mr. **Steinberg**. It is probably in the realm of half of that amount.

Dr. **Gronvall**. I think it is half or slightly more of it that is mandatory. In any event, I am not trying to sound defensive or apologetic, but I think all of these decisions are extremely hard because they come in competition with other highly valid needs for other kinds of medical, surgical, and other kinds of psychiatric problems that veterans face.

Mr. **Steinberg**. I find it interesting that you refer to the possibility of 1989 being a rather bleak year. Imagine how bleak it would be had the two Appropriations Committees granted you your requested appropriation.

Dr. **Gronvall**. I couldn't agree more. Again, I was saying that only to establish a context within which these kinds of decisions have to be thrashed out.

Mr. **Steinberg**. That is perfectly valid.

Dr. **Gronvall**. If you asked me if the Veterans' Administration has assigned, of our own volition, as high a priority for PTSD as high as the extent of that condition and its clear relationship to combat service should require, I think the answer is probably no, for a number of the reasons that I have given.

Mr. **Steinberg**. And that is, obviously, as you state one of the purposes of this hearing, to try to bring about a reassessment.

Dr. **Gronvall**. Of course.

Mr. **Steinberg**. And I take it that you would agree that a reassessment is needed in terms of programs targeted to minorities and women, in view of the findings that RTI has indicated this morning?

Dr. **Gronvall**. Yes. The finding about the extraordinarily higher incidence in Hispanic veterans was a true shock to me, and we were discussing that on the way over this morning. We had had some indications, I think, earlier about the significantly higher incidence among blacks; so that was less of a shock, but it is a stark confirmation of a very difficult problem.

The issue of women, I have not much immediate knowledge with regard to PTSD. Dr. Blank tells me that, if we compared the proportion of women clients who come to our vet centers, women already coming to our vet centers somewhat exceeds the proportion of those women represented in the Vietnam veteran contingent.

So, we will have to look into the women's issue. I heard the testimony this morning, and I was interested in it. Again, those are the kind of details, when we see the backup to the data and have some time to sit down and digest what we should do about, particularly, the incidence information on blacks and Hispanics.

Mr. STEINBERG. And one of the things that needs to be looked at is obviously outreach to those minority and women communities in order to try to deal with the problem because they are being underrepresented substantially in the population of individuals that you are seeing now in the vet centers and in your own programs.

Dr. GRONVALL. Yes, but that appears not to be true for women. I should let Dr. Blank speak to that. He passed that comment on to me.

Mr. STEINBERG. I see Dr. Blank shaking his head.

Dr. BLANK. No, we believe it is not the case, and the GAO Report of August 1987 confirmed that with respect to blacks, I believe. Our data indicate that the percentage of women among vet center clients is slightly higher than the percentage of women among all veterans in the Vietnam era veteran population.

The same is the case for blacks; but as far as I know, there is no data concerning Hispanics. So, that is something we will be looking at.

Mr. STEINBERG. We would appreciate that. On page 15 of his testimony, Dr. Friedman makes a number of points about the inpatient units—the specialized units—that we would like your views on. First, he indicates that his committee's recommendation that these units be site visited every 2 years had been supported by you, Dr. Gronvall; and we would like to know whether such site visits are indeed occurring and what entity is carrying them out?

Dr. GRONVALL. I think we have inadequately followed through on that, but I would turn to Dr. Lehmann or Dr. Errera to comment further. Dr. Lehmann?

Dr. LEHMANN. The special committee did a site visit of each of the 13 then existing units in preparation for, I believe, their second annual report; the 1986 report.

In 1987, there were two site visits that were carried out, one to Lyons and one to Brecksville. There have not been site visits carried out specifically to any of the other units since that time.

At least one reason for that has been cutbacks in appropriation of travel funds. We did not feel that we had the funds to go out and make those kinds of site visits to all of the units in that kind of a time frame again.

Mr. STEINBERG. But you aren't revoking your agreement that that is a desirable policy to pursue—a visit every 2 years?

Dr. GRONVALL. No.

Mr. STEINBERG. I imagine that it is probably fair to say that you haven't adhered to the criterion for various evaluation visits, your internal review schedule itself?

Dr. GRONVALL. Correct.

I was going to make that comment. In a whole range of other review activities where in the past we have made commitments for some schedule of central office review of programs, we have found that those commitments have been impossible to keep.

The central office appropriation in the past couple of years has been cut back by about 25 percent; so we have had a reduction in staff and the concomitant significant reduction in travel and support that goes with that. That is just an observation. So, across the board, those kinds of reviews and surveys have been reduced.

Mr. STEINBERG. On pages 15 and 16, Dr. Friedman discusses his committee's view that there is a need for explicit standards to be used for the evaluation of specialized units; and he also indicates that there has been some concern within DM&S that establishing such standards might have a negative impact on the various units.

Has that difference of opinion been resolved at this point?

Dr. GRONVALL. I don't know whether it has. Dr. Lehmann, can you help with that?

Dr. LEHMANN. The standards, and once again I will get back to the issue of the program guides, one of the things that program guides are going to do is to provide some kind of an idea about the kinds of activities that can take place on various kinds of units in the treatment of PTSD.

I think that the attitude that we have is that having those kinds of guidelines is not going to be too restrictive on the ability of clinicians in the field to innovate programs, based upon the perceived needs of their patients and the skills of their clinical staffs. The point is that there do have to be certain basic characteristics of the treatment of PTSD that are carried out by all programs.

If you take a look at the sections that Dr. Gronvall's testimony includes on treatment, as well as the statements that were written by Fred Gusman and Dr. Scurfield, I think you will find that there is some consistency in the kinds of things that we are talking about that should be characteristic of PTSD programs.

Mr. STEINBERG. And when will that program guide be in existence.

Dr. LEHMANN. I anticipate that the program guide for the general units, with luck, should be published to the field some time by the end of calendar year 1988. I state that because we have had an initial review of the draft of that, and it is in draft revision.

The draft of the guide for the specialized inpatient units, under the direction of Dr. Art Arnold, is in first preparation at this time. Therefore, I would anticipate that that should hit the field some time in calendar year 1989.

Mr. STEINBERG. And the one that is going to be available in 1988 does not deal with the specialized units?

Dr. LEHMANN. No. That addresses the treatment of PTSD in the general psychiatry units; that is its official name. Remember, as we said before, most PTSD actually is not treated in the specialized inpatient units; it actually takes place in other kinds of programs.

The program guide addresses the treatment of PTSD in inpatient units and in outpatient units; and it also has a section addressing the treatment teams.

Mr. STEINBERG. Dr. Errera?

Dr. ERRERA. I just would like to tie the last three questions together, if I may, and link them to something that Dr. Friedman said, which is the importance of the oversight committee in asking these questions. Dr. Gronvall made a very important statement, which is that in American medicine at large, psychiatry is a low priority item.

This is true within the VA as much as it is in academia and in the private sector. So, the only way you can upgrade something like PTSD is if there is a group that specially focuses and pushes in that direction. Otherwise, it is very hard to compete with the high technology fields.

Mr. STEINBERG. Thank you, Dr. Errera. Dr. Friedman also, on page 16 of his testimony, expresses the view of the special committee that at least one specialized PTSD inpatient unit should exist in each region of the country, if not two in the larger regions. Do you have any reaction to that recommendation, Dr. Gronvall?

Dr. GRONVALL. I can't respond to the specificity that there should be a specific one for each region. I think generally when we look to the creation of special units that serve as referral centers, the VA's regions are really administrative entities and don't necessarily make the best definition of a region for purposes of referral of patients.

The general point, though, of assessing the need, looking nationwide at what can be done in each medical center that has a psychiatry service, and then identifying the number of specialized units that serve as backup—in that sense, tertiary—referral centers for the most difficult cases, surely is totally appropriate.

Mr. STEINBERG. And that sort of assessment, I think we have agreed, will be undertaken in an appropriate manner.

Dr. GRONVALL. Yes.

Mr. STEINBERG. On page 17 of his statement—and as you can see, we are progressing through his statement, one page at a time—Dr. Friedman discusses PTSD treatment teams, which the special committee initially recommended be provided to each medical center and later recommended be provided on a phased-in basis over 5 years. I believe these are the teams of two central office provided FTEE.

Dr. GRONVALL. Yes.

Mr. STEINBERG. Four actual clinicians, according to your statement. Dr. Friedman notes that you generally concurred in the 5-year plan; but that after funds were provided for the first 15 teams in fiscal year 1987, no additional teams were authorized in fiscal year 1988. I believe that is correct, isn't it?

Dr. GRONVALL. I would have to look back at the specific comment we made to that specific recommendation when it was made. I think we did not ever specifically concur with establishing a specific 5-year schedule at the end of which we would have a treatment team assigned to every medical center. So, I don't believe we concurred with that fully.

Mr. STEINBERG. But do you believe that you concurred with some phased plan?

Dr. GRONVALL. Yes, we concurred; and again, I am just not remembering the exact details. We concurred that we needed to expand the number of treatment teams and phase them into medical centers. We made a partial response, at least in terms of what the committee had recommended; and that was a decision made on the basis of a resource judgment, balanced against competing needs and in the context of how many medical centers we thought were experiencing a case volume that would deserve that priority.

Mr. STEINBERG. And that is what was done in 1987?

Dr. GRONVALL. Yes.

Mr. STEINBERG. And nothing has been done in 1988 to expand the number of teams?

Dr. GRONVALL. Dr. Lehmann.

Dr. LEHMANN. There has been a proposal submitted by us. Mental Health and Behavioral Sciences Service was requested to submit information on what budgetary requirements there would be to establish 10 other PTSD units in fiscal year 1990.

Mr. STEINBERG. So, the action you are referring to with respect to 1988 has been consideration of doing something in 1990?

Dr. LEHMANN. We were asked to do that this year, yes.

Mr. STEINBERG. Your answer skips 1989; so I think it is fair to say that there is nothing contemplated for 1989.

Dr. LEHMANN. It skips 1988 and 1989.

Mr. STEINBERG. Yes. I was just granting you 1988. [Laughter.]

Dr. LEHMANN. One of the responses the chief medical director made to the special committee's interest in the treatment teams was that further placement of treatment teams might well take place through the medical district initiated planning process.

In order for the medical district initiated planning process to plan to develop treatment teams, they have to know what they are. We are taking a number of steps to educate staff in the field about treatment teams, and the program guide is one; but even before the program guide, the description of VA treatment sites for PTSD which will be shortly released.

Mr. STEINBERG. Dr. Lehmann, excuse me, but do you believe and does Dr. Errera believe and does Dr. Blank believe that if we have to rely on the MEDIPP to get expansion of these treatment teams, that we are going to get any? That is, in view of Dr. Errera's prior testimony about the "poor stepchild" that mental health care is in this country, that the MEDIPP is going to produce a grass roots request for and indication of a need for such treatment teams?

Dr. GRONVALL. If I might just make a quick comment on that—and Dr. Lehmann, you might want to expand on it—the evidence is that a number of our medical centers have specifically developed professionals assigned to operate specific outpatient and inpatient PTSD activities on their own volition, in addition to centrally assigned PTSD treatment teams.

Mr. STEINBERG. Then, let me say that you are not suggesting that it would be an adequate response to rely upon MEDIPP to produce those additional teams, are you?

Dr. LEHMANN. I don't anticipate that the MEDIPP would involve every VA medical center putting in for PTSD treatment teams; but I have seen a significant response of the medical centers in putting in proposals for PTSD, and I keep discovering programs that we have in the field that are involved with PTSD that we haven't even been informed of. We are trying to get more data about that now.

Mr. STEINBERG. One of the reasons we have the central office, I take it, besides being in a position to withstand this kind of a morning and afternoon—is to try to provide some notion of central accountability, central guidance. I certainly dare not use the word "direction."

And it certainly seems to me that there is a need for more central office guidance in the area of PTSD care and in the allocation of resources for that purpose. I was reacting rather strongly to the notion that we are going to kick this back to the MEDIPP and wait on that to become adequately fertilized and grow forth into some sort of either flower or weed.

I just truly hope that that is not the position of your particular division, but rather that, with proper nurturing and guidance and spreading some of the fertilizer that central office is excellent at producing into the field, we might be able to produce a greater outpouring—and if it is MEDIPP that we have to rely on, then it is MEDIPP.

But it seems to me that to rely on MEDIPP to produce it is really to walk away from the problem.

Dr. LEHMANN. I think you have described exactly what we anticipate doing with regard to MEDIPP and PTSD treatment teams and the rest of PTSD treatment. What I was describing was one of the ways in which we are helping the MEDIPP along by helping the field to understand the kinds of programs we are interested in developing; to give them some help in finding out just what they involve and how to set them up.

Mr. STEINBERG. Dr. Gronvall, it is not your testimony, I take it—because you didn't say this, and I hope it isn't your testimony—that we must rely on MEDIPP alone to produce the initiatives in this area?

Dr. GRONVALL. No, clearly I would not say that is the sole response. I would say that in most program areas where we are seeing an expansion of activities, they occur by both processes. We go through central office reviews, identify places where there is a need on a priority basis, reallocate money from something else to do something on the basis of central initiative.

But at the same time as that is happening, as we provide information to the field and there are deliberations at the field level, we regularly find that additional individual medical centers or districts, organize their own programs, find the money or the staff to assign to do the same thing.

That is the reason for Dr. Lehmann's comment that sometimes new clinic activities or inpatient units get started by local initiative, and we only find out about them after the fact since they are doing it out of their own resources.

I think both of those are perfectly valid, and they obviously complement each other; and I don't think we should rely on either one alone. I think it is not sound to conceive that the only way changes occur is by central office initiative and direction. So, I think both of those are perfectly appropriate.

Mr. STEINBERG. Thank you. Dr. Friedman also notes that both DVB and BVA have reviewed data relating to regional office performance and rates of BVA reversals with respect to PTSD disability claims.

Could you provide us with copies of such DVB and BVA reviews, if they exist? Do they exist, Mr. Horton?

Mr. HORTON. The DVB?

Mr. STEINBERG. These are reviews of data relating to regional office performance and the rates of BVA reversals in the area of PTSD.

Mr. HORTON. I am not aware of a study on BVA reversals, but I was relating to you earlier the studies of DVB performance in the field.

Mr. Steinberg. If you would confer with Dr. Friedman by phone and however that is appropriate and make sure that we are provided with whatever data there is in that area, whether from DVB or BVA.

[Subsequently, the Veterans' Administration furnished the following information:]

BOARD OF VETERANS' APPEALS DISPOSITION OF PTSD APPEALS FISCAL YEARS 1984-88—FIRST HALF

Fiscal year	Total decisions	Allowed		Remanded		Denied		Other		Benefits granted	Letter recons
		Number	Percent	Number	Percent	Number	Percent	Number	Percent		
1984..	1,439	308	21.4	271	18.8	857	59.6	3	0.2	23	0
1985..	1,350	257	19.0	317	23.5	768	56.9	8	0.6	107	1
1986..	1,205	184	15.3	396	32.9	616	51.1	9	0.7	122	0
1987..	1,224	183	15.0	453	37.0	578	47.2	10	0.8	116	0
1988 (1st half)..	733	71	9.7	194	26.5	458	62.5	10	1.4	65	2
Totals..	5,951	1,003	16.9	1,631	27.4	3,277	55.1	40	0.7	433	3

Mr. Steinberg. Dr. Gronvall, you refer in your testimony to 97 recommendations in the first 3 special committee annual reports and 42 proposed guidelines in the second report. I realize this may take some period of time, but we would appreciate receiving from you a detailed response showing each of the special committee's recommendations, your response to it, the implementation thus far accomplished, and any plans for future implementation, and a timetable.

Dr. Gronvall. We would be pleased to submit that.

Mr. Steinberg. Thank you.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 479.]

Mr. Steinberg. If you would also, when you give us the August 1 response we talked about, if you can't have such a response to us by that time, give us an indication as to when you could give us this?

Dr. Gronvall. Yes. In any event, we will communicate to you where we stand on it, if we haven't got the work completed.

Mr. Steinberg. That would be fine. With respect to the use of vet centers in helping veterans suffering from PTSD, we were pleased to note the emphasis in your prepared statement on that; and of course, we had substantial testimony on that earlier this morning.

It is obvious from that testimony, as well as your own, that vet centers have been principally involved in dealing with Vietnam and Vietnam era veterans. However, your statement indicates that PTSD is prevalent among war veterans generally, not only those who served in Vietnam, and that little assistance for PTSD was available from either the VA or non-VA sources, according to your statement, prior to 1980.

Does that suggest, and are we to infer from that, that there is a need for vet centers to be doing more in helping veterans of earlier wars, especially those who may have PTSD?

Dr. GRONVALL. I would like Dr. Blank to comment on that, but I would say just a sentence or two. I think, as you know, our vet centers actually do see a number of veterans of other wars; and although the vet center program doesn't have specific statutory authorization to be involved with such counseling, I think we have taken a kind of liberal view in the vet centers that, when a veteran of another war comes in, they can carry the matter through to the point of helping the veteran identify what the problem is and then try to arrange some way to get assistance to the veteran.

Also, as you know, of course that has been a question of specific legislative revision; and the VA's official testimony on that has been to oppose the expansion of the official statutory mandate of the vet centers to include veterans of other wars.

I would ask Dr. Blank to comment on that question, if he wants to.

Mr. STEINBERG. I think Dr. Blank actually already did comment on that question at the hearing that we held approximately 4 weeks ago, and I think I will spare him from having to comment on it again. He looks relieved that he has been spared. [Laughter.]

Mr. STEINBERG. Your answer was certainly very responsive, Dr. Gronvall. Thank you.

Dr. GRONVALL. And it is clear, Mr. Steinberg, that our inpatient treatment units do treat a number of veterans of wars other than Vietnam for PTSD. I think, in the most recent year, if I recollect the figure correctly, we discharged some 10,000 individual veterans from our hospitals. They represented about 15,000 episodes of hospital care; and of those 10,000 individuals, about 2,000 of them were veterans of other than the Vietnam war.

Mr. STEINBERG. On page 2 of your testimony, Dr. Gronvall—and we would appreciate any of the distinguished psychiatrists responding to this—it is stated that: "It is useful to regard PTSD as a spectrum disorder."

And on page 3, it states that: "The treatment needs of veterans with PTSD reflect this variety of degrees of severity in clinical courses."

If a veteran is at the end of the spectrum with more intense needs, what percentage would you say of existing vet centers would be able to furnish services needed by such a veteran?

Dr. BLANK. That is a good question. I haven't really formulated a percentage in my mind.

Mr. STEINBERG. Why don't we let you reflect on that and provide a written answer, in conjunction with Dr. Errera and Dr. Lehmann, if that would be agreeable?

Dr. BLANK. Good. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

Approximately 90 percent of vet centers would be able to furnish services needed by veterans at the end of the spectrum with more intense needs.

Mr. STEINBERG. What I would further like to know at this point is—and it is hard to answer this, I guess, without the first answer—but do you think there is a substantial disagreement within DM&S on the answer to that question? That is: To what extent are the vet centers competent to treat PTSD generally and PTSD at the end of the spectrum?

Dr. **BLANK**. I do not think there is substantial disagreement within DM&S on that point now. I think perhaps up until a couple of years ago, there was; and that probably was based on the fact that, within readjustment counseling service as well as within DM&S generally, we were not clear on what the professional standards of care in vet centers should be.

And we were also in the process of implementing a multitude of requirements concerning that, including a full-scale quality assurance program. So, I don't think there would be substantial disgreement about that at this point in time.

Mr. **STEINBERG**. And is there also not substantial disagreement on whether or not vet centers are generally competent to deal with PTSD up to the end of the spectrum? And is there a general view that vet centers are indeed competent to deal with PTSD from the low grade to the moderate, if not the more severe form at the end of the spectrum?

That is a very convoluted question.

Dr. **ERRERA**. Underlying the question, I think, is to what degree is there disagreement in DM&S; and I would agree with Dr. Blank that I don't feel that there is.

Mr. **STEINBERG**. Do you believe that vet centers are generally competent to deal with PTSD in the nonsevere state?

Dr. **ERRERA**. Oh, absolutely. And I think, as we listened to the testimony of the team leaders, they pointed out that they were quite aware when it was appropriate to refer patients.

Mr. **STEINBERG**. Dr. Gronvall, you were nodding?

Dr. **GRONVALL**. Oh, I was going to nod agreement. This is anecdotal, but when I visit medical centers, I regularly ask questions of that sort. And my uniform experience now is that the mental health staff of whom I have asked that question in the medical centers, say that they have confidence that the vet center refers veterans to them at the appropriate point.

And conversely, I hear the same thing the other way, that in fact our medical center psychiatrists and clinical psychologists refer veterans to the vet centers. So, that represents a confidence that they all receive appropriate treatment there.

I think that the working collaboration has been significantly improved in the past couple of years, as both Dr. Errera and Dr. Blank have said.

Mr. **STEINBERG**. Dr. Blank, what do you believe is the proper role for a vet center staff member to play in connection with encouraging a veteran with PTSD to apply for compensation and in assisting a veteran who does so?

Dr. **BLANK**. I think that, in the first instance, and this would apply to any major or, for that matter, minor life decision made by any patient in psychotherapy or counseling, it is critical for the counselor or the therapist to keep their eye on the main goal of helping the client or patient formulate their own judgments about what is best for them.

This is a critical matter, and it is part of the art of counseling and psychotherapy.

Beyond that, it is a very complex matter as the team leaders indicated earlier. Sometimes it is helpful to folks to get compensation for PTSD; sometimes it is not. And it is frequently very difficult for the counselor or therapist to know in advance what the outcome is going to be.

Mr. STEINBERG. So, this is not a matter on which you have actually issued specific guidance to the vet centers?

Dr. BLANK. That is right.

Mr. STEINBERG. And your testimony is, in effect, that this is a professional judgment that should be made?

Dr. BLANK. That is right.

Mr. STEINBERG. In the particular counseling relationship between the counselor and the veteran?

Dr. BLANK. With an emphasis on helping the client to make the most mature judgment possible.

Mr. STEINBERG. As a general matter, when vet centers refer veterans to other VA facilities for inpatient or outpatient mental health services, do you believe they are successful in having veterans receive the needed care?

Dr. BLANK. Yes, insofar as it concerns an initial evaluation. Staff resource limitations may preclude much treatment beyond the evaluation, at some locations.

Mr. STEINBERG. When they make a referral to a non-VA community source, are the vet centers generally successful in securing what they need in the way of care from such a facility?

Dr. BLANK. I believe vet center staffs generally have become quite expert in networking and brokering for services in the private sector, and I think that is one of the major contributions that they are making.

Mr. STEINBERG. As a practical matter, Dr. Blank, do you believe that vet centers are still able to do the amount of outreach, or that they should be doing the amount of outreach, that was carried out initially in the program?

Dr. BLANK. I think beyond the initial burst of spreading the word that occurs when a vet center opens up for the first time—let's say, for example, during the first 6 months—that the history of our services is that the quantity of outreach provided has been roughly stable over the last several years.

In other words, I think most vet centers are providing about the same amount of outreach now that they were in 1982 or 1983 or 1985, after the first 6 months of their being open. I don't think there has really been a major change in the level of outreach.

Mr. STEINBERG. In view of the RTI findings, as we noted earlier, it seems clear that we should at least for these purposes assume that there are hundreds of thousands of Vietnam veterans suffering from PTSD who have not been seen in vet centers. Indeed, I have read program data that you have put out which is certainly consistent with that statement.

Do you have any views on alternative approaches that might better enable the program to reach more veterans, for example, by breaking up current teams into one or two person teams that might be able to cover a wider geographic area, or using available resources in combination with medical center personnel, teams that could work out of medical centers?

Dr. BLANK. I think that any further geographical dispersion of vet center staff would be quite counterproductive. The four-person team is small to begin with; a three-person team is that much smaller. We have recurrent difficulties both from an operational and a morale and general stamina standpoint with our two-person satellites.

We have a fair degree of what we call "out station" activity at present. It has grown up a bit more in the last couple of years than previously. That consists of having one counselor go to a town at somewhat of a distance, anywhere from 1 to 4 days a week but remaining, of course, a member of the home base vet center.

I think we are doing about as much of that as we can now. So, I don't see any possibility for any further geographical dispersion.

Mr. STEINBERG. Dr. Gronvall, would you have anything that you would add to that?

Dr. GRONVALL. No. I think that is going to require some pretty careful thought. Most of the earlier comments I made today, in fact, reflect a kind of great unease anytime that general question is asked, when surveys turn up people who haven't been seen by anybody and how are we going to reach them and effectively treat them.

That is a really tough question, and we have been through that, of course, regularly in regard to the various kinds of preventive health measures. And the record of really successfully grappling with that and doing it either in the VA or elsewhere is not one that gives me a great feeling of confidence.

Obviously, we will look to the people in our mental health service and the vet center staff to see what they can come up with that will be useful. I don't, on my own, have any very good suggestions as to how we will do that.

Mr. STEINBERG. With respect to training of DM&S personnel, your statement on page 4 provides: "Effective clinical assessment and diagnosis also requires the collection of subjective and often quite subtle personal information from the veteran and skilled assessment of that data with reference to diagnostic standards."

What training is carried out on an ongoing basis to ensure that DM&S personnel who are coming in contact with veterans who may be suffering from PTSD indeed have these skills?

Dr. GRONVALL. I will ask Dr. Lehmann to be more specific about that. Those are the kinds of skills, of course, that said a different way, essentially all of our professional staff who deal with psychiatric and emotional problems need to have to function effectively.

Dr. Lehmann, can you be more specific?

Dr. LEHMANN. I think that has been one of the targets of the educational programs we have been carrying on over the past couple of years, and it is one of the targets that we are going to continue to have.

At least one reason for the need to continue this kind of basic training in diagnosis is because there is a level of turnover that takes place within our system. So just having done educational programs on diagnosis once—which we have done—isn't enough; we need to continue it, as Joan Furey mentioned earlier.

For example, the videotape program that we are going to be presenting this fiscal year, region by region, is going to focus particularly on diagnosis and evaluation; and it is going to be reaching not only our mental health people, but also people who are not necessarily psychiatry staff.

Mr. STEINBERG. With respect to communication, not only as to diagnosis, but also as to treatment, I believe that the vet centers readjustment counseling service has a publication called "The Voice," which is published periodically. Is that monthly?

Dr. BLANK. Monthly, yes.

Mr. STEINBERG. That includes a substantial amount of communication with all the vet centers and among themselves as to what is being tried and what may be working and what may not be working at various vet centers.

I am not aware that a similar type of education program is in existence with respect to the rest of the health-care program, particularly as it is dealing with PTSD. Dr. Errera?

Dr. ERRERA. That was one of the mandated functions of the Center for Stress. You are absolutely right.

Mr. STEINBERG. We were just moving into that.

Dr. ERRERA. And we agree with you. That was one of the other findings that we had, that they were not carrying out these functions, although that is one they did better than the other. They did a better job with education than with research.

Dr. LEHMANN. Yes, and there has been and there is continuing a quarterly PTSD newsletter, the distribution of which is designed to go particularly to the specialized units, vet centers, and other psychiatry services.

Mr. STEINBERG. But does that go to the vet centers as well?

Dr. LEHMANN. Yes, it should.

Dr. ERRERA. The Great Lakes REMC's have been doing that.

Mr. STEINBERG. Dr. Errera, I didn't hear you.

Dr. ERRERA. I said this was put out by the Great Lakes REMC even more than by the Center for Stress.

Dr. LEHMANN. Yes. Mid-Atlantic REMC has been the one that has been carrying that, and we have asked them to continue that until such time as a new national center is designated.

Mr. STEINBERG. How many such quarterly publications have there been?

Dr. LEHMANN. Sixteen, I believe.

Mr. STEINBERG. This has been going on for 4 years?

Dr. ERRERA. Quite a few years, I would say.

Dr. LEHMANN. Yes.

Mr. STEINBERG. Could you provide us with back copies if they exist and also provide us in the future with those documents as they are issued and provide a concurrent copy to the minority, please?

Dr. LEHMANN. Certainly.

[Subsequently, the Veterans' Administration furnished the following information:]

Back copies of the PTSD Quarterly Newsletter which are available, follow. The VA will provide to the committee all future such publications.

[The back copies of the PTSD Quarterly Newsletter are retained in the committee files.]

Mr. STEINBERG. On page 17 of your statement, you discuss—and you just made reference to—the probable transfer of the national center from Brecksville to somewhere else. Obviously, one of the principal questions in the establishment of a center, either a multisite or single site design, is going to be the FTEE and the resources assigned to it.

I wondered what your plans are in order to make that a meaningful start—second start—with respect to those resources in FTEE. I believe we heard this morning that Brecksville was funded at $1.4 million. Is that essentially correct?

Dr. GRONVALL. I think that is close to right. I don't know the exact figure. Let me comment on this in a general way. Our hearing statement is, I think, fairly clear on this.

We had established the center, gave it a chance to operate for about 3 years. There were surely warning signals along the way. We then conducted a formal evaluation and concluded that we needed to make a change. The starting point, of course, for a change would be that the resources being invested in the current center could be relocated.

I think no decision has been made on the extent to which resources beyond that might be necessary, particularly to initiate a center if it is going to move somewhere else. Typically, as your earlier question suggested, there are some startup and then recurring costs.

I know that the people in mental health and Dr. Errera should speak to this. They have been working on the general process of issuing an RFP, soliciting proposals and developing the guidelines within which such proposals would be reviewed and the decision made to relocate the center.

Mr. STEINBERG. Apparently, the special committee is going to have a recommendation to make to you with respect to resources. I assume that that will be seriously evaluated.

Dr. GRONVALL. Absolutely.

Mr. STEINBERG. What do you assign as the basic reasons for the fact that the center, as currently constituted, has not been successful?

Dr. GRONVALL. I think Dr. Errera probably ought to speak to that.

Dr. ERRERA. I think the way it was selected. I was in the field at the time, and we all were quite surprised when it was selected, the way it was selected, and where it was selected.

Cleveland had no special interest or ability in the treatment of PTSD. The University and the Case Western Reserve Medical School had no special interest.

Mr. STEINBERG. And the current process will rectify those problems, or that particular problem?

Dr. ERRERA. Correct.

Mr. STEINBERG. Do you have any comment at all on the multisite versus single site discussion that we had earlier with the special committee?

Dr. ERRERA. Yes. I think we want to pursue excellence; and depending where we get it, we would go one way or the other.

Mr. **Steinberg**. That is almost as good as one of your answers, Dr. Gronvall. [Laughter.]

Dr. **Gronvall**. I am always pleased when other members of the staff can exceed me. [Laughter.]

Mr. **Steinberg**. Is there a timetable for a decision on the center?

Dr. **Gronvall**. Dr. Errera?

Dr. **Errera**. Yes. Dr. Lehmann has been working on it; and tentatively, it is January 1.

Dr. **Lehmann**. We are hoping that we would be able to designate a new center by January 1, 1989.

Dr. **Errera**. There is the question of the funds, though.

Mr. **Steinberg**. But there presumably are some existing funds, as Dr. Gronvall indicated, that could be reassigned?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. Supplemental funds is another matter. I take that will be looked at, as Dr. Gronvall indicated. When are the proposals due back, or are they back?

Dr. **Lehmann**. They are not out yet. We have a draft form of the Request for Proposal package. In fact, the issue of finances has been one of the things that we are looking at; but we are not waiting for the final resolution of that to send that Request for Proposal package through for its initial review. In fact, it isn't the initial review because we have already had input from a lot of people in putting that proposal together including, by the way, the recommendations of the special committee.

We are going to have that reviewed by a group in CO and in the field. We will have it, I would hope, through its concurrence channels and out into the field, by some time in August. That should give several months for the field to prepare thorough and detailed RFP responses.

These then will be reviewed by a committee to determine which of the proposals will best meet the demands for excellence that we are going to require of it.

Mr. **Steinberg**. What is the line accountability between the center and either your division or the research responsibilities of Dr. Greene or the operational responsibilities of Dr. Winship?

Where does the responsibility lie as between research, behavioral sciences, and operations?

Dr. **Gronvall**. Dr. Lehmann?

Dr. **Lehmann**. We have a proposal in the draft format, and this is one of the things that I am going to hope to get concurrence on from the people who are commenting on it. Research and Office of Academic Affairs will be included in that. The bottom line is that we want to be able to have an administrative structure that is acceptable to the VA medical center in the field but, at the same time, is going to be able to provide a sufficient amount of administrative oversight from central office to be sure that the new national center is helped to achieve the goals that we wanted to.

Mr. **Steinberg**. That sounds highly laudable, but that isn't what I asked. Who at present is responsible in the central office for the center?

Dr. **Errera**. Let me respond to that because it is a nice example of why it is easier to initiate a new program then to revise an established one. It was much easier for us to start the homeless chronically mentally ill program than it was to try to change or restructure the Center for Stress Recovery because of the question you are raising.

Mr. STEINBERG. Would it help if we indicated in the statute where that responsibility should lie?

Dr. ERRERA. No.

Mr. STEINBERG. Since you seem to be at a loss to answer either as to where it is or where it will be.

Dr. ERRERA. Oh, I am not at a loss. I will defer to the chief medical director first. [Laughter.]

Dr. GRONVALL. I don't know who the center director reports to. He does not report to me; and so, I do not know the line of responsibility.

Mr. STEINBERG. We need to have Dr. Winship here because, in these situations, he says: I guess it is me. [Laughter.]

Dr. LEHMANN. We could say we guess it is Dr. Winship.

Dr. ERRERA. I have two suggestions, Mr. Steinberg.

Mr. STEINBERG. I am sorry. Dr. Lehmann, I missed your last statement; and then we can go to Dr. Errera.

Dr. LEHMANN. I said we could say that would be Dr. Winship, but that wouldn't be fair. I have a comment, but let Dr. Errera go first.

Dr. ERRERA. There are two suggestions. One is the suggestion of the special committee, which is that that person should report to the chief medical director. I don't happen to agree with that; I think the person should report to the chief of staff and the Medical Center Director, as well as centrally.

Mr. STEINBERG. As well as centrally where?

Dr. ERRERA. Well, if you asked me, I would say to my office.

Mr. STEINBERG. And have you sought that?

Dr. ERRERA. Yes; we are in the process of negotiating, sir.

Mr. STEINBERG. And is this one of the reasons perhaps why the center may not have been quite as successful as it might be?

Dr. ERRERA. No.

Mr. STEINBERG. Obviously, there is no one in central office to whom the center is responsible; and, therefore, there is no one in central office who is responsible for the center. Is that correct at this point?

Dr. ERRERA. At this point, the lines of authority about who is responsible for the center are strained between the region and central office. That is true.

Mr. STEINBERG. And should there be, Dr. Gronvall, in central office an individual to whom you can look and to whom we can look as being responsible for the center, along with the field personnel involved?

Dr. GRONVALL. Clearly, there needs to be a line of responsibility. I was going to say that our experience across the board is that every time we set up a special center in a medical center—and we have been through this with regard to the GRCs—and a whole host of similar special——

Mr. STEINBERG. But the law specifies to whom the GRCs report in Central Office.

Dr. GRONVALL. What I was going to say is that, in each case, our experience is that in order for the center to be successful, it has to operate with a local accountability to the Medical Center Director and chief of staff so that it gets viewed locally as functioning as an integral part of the medical center operation.

At the same time, in order to accomplish a national mandated mission that comes out of the central office, there needs to be an accountability to some specific office in the central office. So, while that sounds mushy, I think the inherent fact is that a center is a kind of matrix organization that does have dual lines of responsibility, both to the individual medical center that it exists in and to somebody in the central office.

Mr. **Steinberg**. Let me see if I can understand. You have how many spinal cord injury units?

Dr. **Gronvall**. I don't know the number, but we have a number spread across the country.

Mr. **Steinberg**. I am sure we can find that out in just a moment.

Dr. **Gronvall**. Yes, and there is a director of the Spinal Cord Program in the central office.

Mr. **Steinberg**. Right, and you know who that is?

Dr. **Gronvall**. Yes, absolutely.

Mr. **Steinberg**. And you have a certain number of prosthetic units, I am sure, that the DAV and PVA can tell us how many they are?

Dr. **Gronvall**. Absolutely.

Mr. **Steinberg**. And they have a responsibility in central office to the prosthetics director—I don't have the correct title in my mind—but Mr. Downs; is that correct?

Dr. **Gronvall**. Absolutely. If the point of this is does there need to be an individual office designated that is the central office point of responsibility for what goes on, the answer is clearly yes. My answer is that it does not mean that the center director of such a center that has a research, education, and clinical care mission reports only to a specific office in the central office.

Mr. **Steinberg**. We already have the schizophrenia of having him be responsible to his chief of staff and center director, which is surely going to be the case to some extent, and his regional director.

Dr. **Gronvall**. Correct.

Mr. **Steinberg**. And it seems to me that the simpler we make the lines of accountability in terms of reporting in central office, the more effective they might work.

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. Now, once in central office, you obviously have a committee type of arrangement such as exists, I believe, with respect to the GRECC's, which have multiple responsibility?

Dr. **Gronvall**. Absolutely.

Mr. **Steinberg**. And such as we hope will exist with respect to the MIRECC's in the future. When can we get a decision from you on the question of accountability in Central Office and how that will be structured?

Would that be reasonable to have by August 1?

Dr. **Gronvall**. I gather that a recommendation has been made by the mental health service as to how the restructured national centers should be organized administratively. That is being reviewed by other offices, and I was unaware of the discussion going on on that issue. I would have to ask them where it stands and what is a reasonable time to conclude that.

I think to artificially force an answer is not wise. I think in order for an organized center that has to operate in a kind of matrix fashion and have research, education, and clinical care function and balance between being in a medical center and yet being a national center, it is in fact wise to really spend some time thinking about how that is going to work.

Mr. **Steinberg**. You have had a considerable amount of time to spend thinking about that question.

Dr. **Gronvall**. I assume that the reason that a proposal is being made to change it is that the present arrangement that we have had in Cleveland has not been satisfactory. So, I am assuming that is the basis of the proposal to change it.

Mr. **Steinberg**. It wasn't the present arrangement in Cleveland that we were referring to. We were referring to the present arrangement or lack of arrangement in central office. And I might say that there are times when I feel that it is necessary to force a decision artificially.

I would suggest to you that, if you can respond within the timeframe prior to our taking up S. 2011 on the Senate floor, you might avoid an effort to establish that line of accountability insofar as the Congress is concerned.

So, I will leave that to you in terms of how quickly you can deal with that administratively; but I would feel remiss in taking that bill to the floor, which deals with the Special Committee and its continued viability, which grew out of the same legislation that established the center—legislatively established the basis for the center—if we didn't try to answer the question, if you had not answered it in a satisfactory manner prior to that time. So, I would suggest some sort of a target of the 25th to the 27th of July to try to come to grips with that.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 489.]

Mr. **Steinberg**. On page 19 of your testimony as to research, you note that 67 research projects on PTSD were approved in 1987. Were all of these fully funded?

Dr. **Gronvall**. Dr. Greene is here and can speak to that.

Dr. **Greene**. No; they are not all fully funded. As you know, because of recent budget constraints in research, we fund all projects on a sliding scale.

Mr. **Steinberg**. But had there been the prior system of priority research in effect, then PTSD would clearly meet the designation of priority research, I take it?

Dr. **Greene**. Yes, that is correct.

Mr. **Steinberg**. Then there would be full funding.

Dr. **Greene**. That is right. That was withdrawn in 1986 after the major cuts to research service from the Gramm-Rudman reductions and has not been restored because we are still in a very tight budget circumstance.

The tradeoff is whether we fully fund a certain set of projects at the cost of not funding other worthwhile projects at all. So, the tradeoff that we have debated and discussed with our advisors has been not to provide any special funding.

Mr. STEINBERG. We understand the conflict.

Dr. GREENE. Right, and it is a stress.

Mr. STEINBERG. If indeed we are not sympathetic to it. Would you give us for the record, please, a discussion of the pros and cons of that issue?

Dr. GREENE. Certainly.

[Subsequently, the Veterans' Administration furnished the following information:]

I know of no practical and responsible way to give priority to one group of scientists versus another. Would funding clinical research on PTSD necessarily have greater payoff, in terms of developing effective treatment. Than funding some other area, such as basic neuroscience research? We have no way of knowing. The history of science has shown clearly that problem solutions often come from completely unexpected, sources. The research conducted by Dr. Rosalyn Yalow, one of the VA's Noble Prize winners, is a prime example. Her original basic research turned out to have completely unanticipated applications in developing an epochal breakthrough in diagnostic and therapeutic technology. The view I am defending is a prominent one among research aministrators and science policy analysts.

Mr. STEINBERG. And I take it that, at the moment, there are no plans to reestablish the priority research designation? Or is that a matter that is being pursued in accordance with one of your advisory committees, Dr. Gronvall, or anything like that?

Dr. GRONVALL. Dr. Greene.

Dr. GREENE. The issue of a priority status in particular for PTSD is not——

Mr. STEINBERG. I was referring generally, generally to the question of whether there would be priority research projects funded at 100 percent, as compared to nonpriority research projects which would be funded at a lower proportion.

Dr. GREENE. Right. The Medical Research Council, having debated this last month, has recommended that if the budget level for fiscal year 1989 is the most optimistic budget level that we can envision, then we should try to fully fund virtually all of the research projects that are supported in priority score order.

And I think, depending on what the final budget is, that we would then be able to stretch further in terms of reaching more research projects than we have in the past. The answer is that we are not going to separate out one particular area but try to reach full funding for most of our projects.

Mr. STEINBERG. There does seem to be somewhat of a decision from the VA's mission, particularly as it was reemphasized in the recent public law enacted on May 20 with respect to service-related matters being given emphasis in research, to merely assign priority scores to all research and then fund them in the order of that priority score.

If it is too extreme to have a system whereby all research in a priority category such as PTSD is funded ahead of all so-called nonpriority research, then surely there is room for some melding of the two systems so that there would be an overall research priority score; but in addition, there would be certain weight attached to proposals which fit within the priority category, such as PTSD, SCI, Alzheimer's, I believe, and a number of others.

What would be wrong with something that would blend these two together?

Dr. **Gronvall.** Dr. Greene, do you want to comment? And then, I would like to add a comment of my own.

Dr. **Greene.** I would just like to echo what Dr. Gronvall said earlier about priorities and that one measure of priority is the amount of money being spent in a particular area. I would just point out that in PTSD the amount of funds being spent in research have more than doubled in the last 4 years, to the point that we are now spending over $1 million a year.

Now, is that enough? I would say no; it is not enough. I think the place where there will be an opportunity to expand the level of PTSD funding significantly is with the new center. That did not happen with the old center, but I see this as an opportunity of moving in the direction of having more high quality PTSD research.

Mr. **Steinberg.** I follow that, but I am talking more generally about the question as to whether or not the research mission of the Agency, as to which Congress itself has set certain priorities, should recognize in the grant application process those priorities set forth in statute and other documents of the agency establishing such priorities.

At the moment, there is no recognition of that.

Dr. **Greene.** That is correct. If I could add just one other point on this general debate?

Dr. **Gronvall.** Go ahead.

Dr. **Greene.** I have reviewed in preparation for this hearing all projects that were reviewed in the last two rounds of merit review. In terms of the projects that did not make the funding cutoff, the review boards make recommendations for strengthening these studies. These unfunded projects will be improved through rewriting and integrating the reviewers' suggestions.

Mr. **Steinberg.** I think you are responding to the question of whether or not all priority projects should be funded at 100 percent. What I am inquiring about is whether or not there cannot be a weight afforded the priority rating system for priority projects so that the best priority projects or the better priority projects will indeed be funded, if not at 100 percent then at a higher percent than comparable projects in quality, nonpriority areas.

I would ask Dr. Gronvall if he would respond to that.

Dr. **Gronvall.** I will be glad to make some comments to it. It gets off into a fairly long discussion, and I am unaware of any really very substantial evidence when one looks in retrospect that application of those kinds of priorities in advance over time really bears much relationship to progress made in regard to various kinds of medical and diagnostic and therapeutic problems that we face.

In fact, so far as I am aware, when people look back at the evolution of the research work that leads to new diagnosis or new treatment in any given area, most of the very important work that leads to those advances was done by people who, at the time, would never have thought they were working on anything related to that particular disease; and the project would never have been related to it.

So, I am much less enamored with the idea of identifying that, because this given problem is one that is unique or particularly important to the VA, then let's fund all of the research that people themselves say is research related to that particular disease or problem because I don't think research really works that way over time.

We do have prioritization. We have several pockets of our research program that is divided up. We support medical research. We support health services research. We support prosthetics research. And there are subdivisions and priorities; I am not disagreeing with that.

We have taken special emphasis areas or priority need areas and dealt with them in a number of ways. We have put out special initiative funds to try to encourage people to get going developing projects in given areas. In the area that we are talking about, which I would call mental health or psychiatric research, we have conducted training programs explicitly to try to help expand the number of investigators who are doing work in that area and help them improve the quality of their research proposals.

So, I think we have done a lot of things to try to match the research emphasis, mission, and process that leads to funding decisions to the kinds of things that are most important to the VA; but I really do have a very low opinion of efforts to try to say that, since *X* percent of the cases we see in the VA suffer from such and such a disease, let's be sure we spend *X* percent of our research money in that area or schemes of that sort. They just don't pay off.

Mr. **Steinberg**. Again, I certainly did not suggest any such percentage set-aside, but you certainly indicated your policy preference clearly; and I think it is not going to be availing to continue that particular dialog.

Dr. **Gronvall**. My position is based not just on a personal observation, but I think a fair amount of pretty sophisticated assessment of how research gets done that leads to improvements in diagnosis and treatment of disease.

So, it is not just a personal opinion, I don't think.

Mr. **Steinberg**. Dr. Greene, how many PTSD-related research projects were turned down—not approved—in 1987? Sixty-seven were approved.

Dr. **Greene**. I don't have the exact number; I can give you a ballpark figure and give you the exact number for the record. I think there were about 5 or 6 in 1987–88 that were turned down.

Mr. **Steinberg**. So, if you would provide those specific numbers for the record?

Dr. **Greene**. Yes.

[Subsequently, the Veterans' Administration furnished the following information:]

Three projects were disapproved in 1987–88 and one project was deferred.

Dr. **Greene**. If I might say, there is one project in the gray area for this last round in PTSD, and we are hoping that, if the best projection of the budget comes through, it will be funded.

Mr. **Steinberg**. Since you indicated earlier that there wasn't enough research in this area, do you have any plans to try to stimulate research into diagnosis or treatment of PTSD?

Dr. **Greene**. I think there are two areas for enhancing PTSD research. One is assuring that the new center is a center of excellence in research, and we certainly will work with our colleagues in mental health to assure that.

In addition, the new data, which is obviously going to be very rich from RTI, is a source of secondary analysis; and we have already talked with Terry Keene about the possibility of trying to arrange a vehicle for making that data available to researchers to further mine it. So, those are two specific areas.

Mr. STEINBERG. As to the second one particularly, as I am sure we will learn about the first one, would you keep the committee advised as to the second one in terms of mining the RTI data?

Dr. GREENE. Yes.

Mr. STEINBERG. Do you have any plans, or do you think you should have any plans, to promote research in the area of diagnosis and treatment of individuals with both PTSD and a substance abuse problem? Do you feel that there is any need for more effort in that area?

Dr. GREENE. I think it is certainly a subset of the PTSD problem. There are some research projects going on in that area. We don't have any specific program plans to solicit additional projects.

Mr. STEINBERG. There are research proposals in that area specifically?

Dr. GREENE. Yes.

Mr. STEINBERG. Would you provide us for the record with descriptions of those projects, please?

Dr. GREENE. Sure.

[Subsequently, the Veterans' Administration furnished the following information:]

Although only one currently active project deals explicitly with the PTSD and Alcohol/Drug combination (MMPI Correlates of PTSD and Alcohol-Drug Patients), the issue of substance abuse is implicit in several projects. This is true because, as is noted in the DSM III manual, Psychoactive Substance Use Disorders are common complications of PTSD. Therefore, PTSD studies concerned with the diagnosis of the disorder or with the outcomes of treatment interventions will almost inevitably include substance abuse in the assessment procedures.

Mr. STEINBERG. Dr. Gronvall and Mr. Horton, are you generally satisfied that at this point your two departments are doing everything that needs to be done and can be done to coordinate your PTSD diagnosis policies and guidelines and to provide training and education in this area?

Dr. GRONVALL. I would think any time you ask me a question if we have done everything we possibly could, the answer is no. The extent of the collaboration between the two departments is something that I am not personally aware of as a generalization.

I think you have heard testimony here that the medical diagnosis issues get worked on hard in the Department of Medicine and Surgery, and there is a fairly arm's length relationship between the process used for DVB adjudication of claims where we in the Department of Medicine and Surgery have made a particular medical diagnosis.

In this area, it is even further complicated by the impact of seeking compensation on the individual's medical or psychiatric or counseling care.

I think Grady may have some comments, and then I think the informed answer from the department about the extent to which we are collaborating should come from either Dr. Blank or Dr. Errera.

Mr. **Steinberg**. Grady.

Mr. **Horton**. I believe this represents an instance that the two departments have collaborated on very well, particularly using the special committee as a vehicle. They have looked into the way we have handled claims and have made recommendations to you, as the testimony indicates. We have accepted virtually all of those recommendations.

We have been engaged in training sessions with them, with DM&S jointly and collaboratively. I think it is one of our success stories. We still haven't got all the problems worked out; but, on a scale of 1 to 10, 8 years is not very long to be working on the PTSD problems that we have.

Mr. **Steinberg**. But in 8 years, up to this point, you have not produced a training module for your C&P physicians who are diagnosing PTSD for purposes of claims adjudication? Up to this point, none has been produced; is that right?

Dr. **Blank**. As a matter of fact—and Larry Lehmann may be able to add some details on this—the joint REMC, Mental Health, and Readjustment Counseling Service Committee on Training initiated the preparation of a video tape which will be precisely that. And that work is now underway.

To my recollection, this was discussed at a meeting about 2 or 3 months ago. My recollection is that we have a timetable for that to be completed this autumn.

Mr. **Steinberg**. Is that right, Dr. Lehmann?

Dr. **Lehmann**. Yes; there are four specific items that I can comment on with regard to cooperative efforts in terms of coordinating policies in education. First has been the parallel development of circulars by DVB and DM&S on the diagnosis of PTSD. We have used that—the format of the DM&S one—as part of our education in the field.

Second is the education in the field itself, beginning with the regional educational programs that were mentioned earlier for the chiefs of psychology, psychiatry, and nursing. We also carried those out—at least the last two, and I believe also in some of the earlier ones—with DVB personnel participating in those.

In addition, centrally, we have had several educational programs presented to DVB adjudicators and to the staff of the Board of Veterans' Appeals on the issue of PTSD diagnosis.

And finally, the C&P physicians training module that we have been talking about. In fact we are going to have a planning conference on it tomorrow; and we are anticipating some time this autumn to be able to put it in the field.

Mr. **Steinberg**. We would appreciate your sharing with us that particular module when it is available.

Dr. **Lehmann**. Gladly.

[Subsequently, the Veterans' Administration furnished the following information:]

This training module will not be available until early FY 1989, at which time, a copy will be made available to the Senate Veterans' Affairs Committee.

Mr. **Steinberg**. We will be patient in observing the process of bringing about cooperation between these two giant entities.

Dr. **Gronvall**. I might make one other comment since you used the general term "C&P exams." We have had a joint effort going on between DVB and DM&S this past year because we recognized that the Department of Medicine and Surgery was not adequately carrying its weight and responsibility in regard to C&P exams.

There were some technical administrative problems between the two departments in that we use different yardsticks of when a report was on time and when it wasn't and so forth. So, we have gotten those worked out, and we have staff from Dr. Winship's office and staff from Ray Avant in DVB who are following up on those items.

I also now am getting a periodic management report that is subdivided by region that shows the status of DM&S timeliness on compensation and pension exams. I have had discussions with the regional directors on at least two occasions, specifically on those reports.

And I have just come back from a series of regional budget discussions where I have been meeting with all of our directors and chiefs of staff, and that is one of the points that I made in a short overview comment that needed a boost in several parts of the country.

So, Dr. Errera earlier made some pretty negative comments about the way the department in some respects has handled C&P exams; we have been working on trying to get better control of that and change the priority and have a tighter leash on our medical centers in terms of performing those exams.

Mr. **Steinberg**. Could you provide for the record a little bit more description of the extent to which there were these different standards and how that has now been resolved?

Dr. **Gronvall**. Yes. We can supply a summary report that points out what agreements we adopted and how we are tracking them. We would be pleased to.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 492.]

Mr. **Steinberg**. Grady, did you have anything more you wanted to say on this?

Mr. **Horton**. I would just add that, in the last 2 years, we have conducted training for rating specialists from every office in the country on PTSD, included in other training we conducted; and DM&S personnel participated with us in that.

So, it has been working in both directions.

Mr. **Steinberg**. I would like now to yield to the minority general counsel, Tom Roberts, for any questions he may have.

Mr. **Roberts**. Thank you, Jon. Senator Murkowski, both as former chairman and now ranking member, has been vitally interested in PTSD; and the minority side of the committee has been closely monitoring the reports on this extremely important issue.

We did have a rather extensive set of questions, which he wanted me to pose today; and I am sure that our witnesses are chomping at the bit to deal with those questions, and our guests here are sitting on the edge of their well-worn seats to hear the answers.

Dr. **Gronvall**. Occasionally, I have been faced with that same question, and my answer is that as long as anyone wants to ask questions, we are here to respond. I can assure you of that.

Mr. **Roberts**. I am afraid I must dash your hopes, Doctor. [Laughter.]

Mr. **Roberts**. We will submit the great bulk of ours in writing. I do have two quick questions. My first question is one that Senator Simpson asked me to ask. This would be directed to Grady Horton.

Bob Meredith from Cheyenne, team leader from the vet center there, referred to—and I don't think he was trying to give an expert opinion—the number of PTSD claims which were allowed at the Cheyenne office. I believe he mentioned something in the range of 5 to 10 percent. Grady, do you know what the actual percentage is?

Mr. **Horton**. Our statistics indicate 37.8 percent.

Mr. **Roberts**. What is the nationwide average on that?

Mr. **Horton**. The nationwide average is 54 percent.

Mr. **Roberts**. And Dr. Gronvall, I want to ask you first a "yes or no" question.

Dr. **Gronvall**. All right.

Mr. **Roberts**. There is a provision in S. 2011, as reported by the committee, having to do with providing treatment for veterans diagnosed with PTSD but not having had service connection for PTSD adjudicated. My "yes or no" question is: Have you given any thought to that provision?

Dr. **Gronvall**. Yes.

Mr. **Roberts**. All right. [Laughter.]

Mr. **Roberts**. My next question is: In view of the fact that the team leaders this morning seemed to indicate—at least as far as I understood—that that kind of provision didn't seem to affect directly the amount of treatment which would be available or, in fact, the priority of treatment in the field for vets with PTSD, what kind of effect do you think that provision would have if we enacted it?

Dr. **Gronvall**. I don't have a way to say, really with any confidence, what impact it would have. I heard the testimony here that, whenever a vet center team makes the judgment that someone needs to be referred to a hospital and they need to get hospital care, they are not having problems in getting that kind of priority.

That does not surprise me because of what I believe the priority would be on assuring in one of our hospitals that a veteran with PTSD who needed hospital care would get it. So, if the question is to take a specific piece of legislation that has details in it and try to translate to a nationwide impact, the only way we could respond to that would be by specific review and an attempt to make a detailed assessment.

Mr. **Roberts**. And will you do that for us?

Dr. **Gronvall**. Has the Veterans' Administration been asked to review and comment on the proposed legislation? I said yes——

Mr. Steinberg. There has been no such formal request because the legislation is included in a report and was not introduced separately. So, there was no bill referred to our committee on which you could be asked to comment.

Dr. **Gronvall**. Yes; when you asked me if I had thought about the question, I said yes because I had heard the legislation previously verbally described; but then, I don't believe we have had the written legislation under review in the Veterans' Administration.

Mr. ROBERTS. I think—and Jon, you can correct me if I am misinterpreting this—that one of the hopes of the committee is that one of the effects of this legislation would be to urge or force the VA to reallocate resources.

Mr. STEINBERG. That is absolutely correct, and we will be glad to provide a copy, Tom, of the legislation, which I think is in quite finished form at this point, to Dr. Gronvall and the Agency for them to respond to your question.

Dr. GRONVALL. Let me be sure that I am responding in the right way. As I heard it described, what I assume would happen is that as soon as a diagnosis of PTSD had been made, in essence the veteran would be treated as a——

Mr. STEINBERG. Excuse me. A diagnosis of PTSD related to service.

Dr. GRONVALL. Yes, correct.

Mr. STEINBERG. In Vietnam.

Dr. GRONVALL. Yes, related to Vietnam service is made, in essence, the veteran would become a category A veteran with mandated eligibility for inpatient care or outpatient care.

Mr. STEINBERG. Mandated eligibility for both and the same priority for outpatient care as though the veteran had a service-connected disability that was being treated—in other words, the first priority.

Dr. GRONVALL. Yes.

Mr. ROBERTS. I am sure that we would like—and I suppose we are going to do it in some other way—to get Dr. Gronvall's comments on that.

Mr. STEINBERG. We will submit the actual legislation to you, and we will request that you give us a formal agency report on the legislation.

Dr. GRONVALL. And again, as a generalization then, what we would have to do is make a detailed assessment of the extent to which we thought there were situations where that in fact did not exist and, therefore, what would be the expansion of medical care so mandated. And then, if no resources were provided, that would come at the expense of care for veterans lower on the statutory eligibility list.

Mr. ROBERTS. I am certain, Doctor, you will find a way to respond to it. Jon, that is all I have. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

The Veterans' Administration does not support this provision. One of the reasons for opposing this measure is that it would be the first instance of a priority for care being given on the basis of a particular diagnosis of a disorder incurred by veterans of a single war. If PTSD treatment needs a greater priority in the VA, the Agency should have the opportunity, as we testified at the recent hearing, to devise ways of providing this priority within the total health care system operated by VA, without such a legislative constraint.

We object to this provision further because it would treat veterans as service-connected when they have not been formerly adjudicated service-connected. Under the measure, all that is needed is that the diagnostician determine that PTSD is service-related, and that the veteran produce evidence of Vietnam service. We are concerned about the confusion which could result from veterans learning that VA will treat them for PTSD, but that they may not be eligible for compensation for the disorder.

[Subsequently, the Veterans' Administration furnished further information which appears on p. 506.]

Mr. **Steinberg.** I might say that we did have testimony, and I think you are aware of at least one or more instances where there are waiting lists at the inpatient PTSD units. We had testimony that there was such a waiting list at Togus, Maine; I am sure that is true for some of the others.

And in those instances, clearly, the intent of the legislation would be that resources would have to be allocated to try either to deal with those veterans who are on that waiting list at such centers or to find other places to deal with them in a priority manner.

Dr. **Gronvall.** I understand.

Mr. **Steinberg.** Tom, thank you very much. Dr. Gronvall, you and all those with you have been remarkably patient and generally responsive. We thank you very much for bearing with us so long throughout this day. I am advised, Dr. Gronvall, that your presence in the Congress is still desired, even at this late moment.

Dr. **Gronvall.** Yes, thank you. [Laughter.]

Mr. **Steinberg.** And now, our final, long-suffering panel will please come forward: Mr. Albert J. Bland, national commander, American Ex-Prisoners of War, accompanied by Mr. Chuck Williams; Mr. Sam Walsh, assistant legislative director, the American Legion, accompanied by Mr. John Sommer, director of Veterans' Affairs and Rehabilitation; Mr. David W. Gorman, assistant national legislative director, Disabled American Veterans; Mr. Gordon Mansfield, associate executive director for government relations, Paralyzed Veterans of America; Mr. James N. Magill, director, National Legislative Service, Veterans of Foreign Wars of the United States; Mr. Thomas A. Sherwood, national director of health policy and planning, Vietnam Veterans of America, accompanied by Mr. Steve Bentley, national chairman, Vietnam Veterans of America Special Committee on PTSD and Substance Abuse; and Mr. Ray Field, chairperson, Veterans' Administration advisory committee on native Americans and native Hawaiians.

I don't know whether I should ask you to vote again. I think I will resist that temptation and ask if Sam Walsh would please lead off.

STATEMENT OF JOHN F. SOMMER, DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. **Sommer.** Thank you, Mr. Chief Counsel. Sam is not with us, so I will present The American Legion's summary.

Mr. **Steinberg.** Please do. We exhausted the legislative division's resources this afternoon. We appreciate your bearing with us so long, John.

Mr. **Sommer.** We feel very strongly about the importance of the work that is being done by the chief medical director's Special Committee on PTSD. So, we are pleased that it looks as if there will be an extension of the life of that committee.

The vet center program has become an integral part of the overall VA health-care delivery system enhancing the continuity of care and greatly improving the understanding throughout the Veterans' Administration of the psychological needs of combat veterans.

We find that the program is continuing to do well in accomplishing the purpose for which it was established; and as has been discussed here today, the workload totals including new veteran clients remains very high.

We were asked to comment on the Vietnam Experience Study conducted by CDC, and we have addressed that in some detail in our written statement. With respect to the PTSD findings, we feel that their importance was minimized in the final report.

Time was not sufficient to complete anything other than a basic review of the preliminary findings of the National Vietnam Readjustment Study. However, it is obvious that the findings of this study will be a substantive and an important addition to the body of knowledge relating to PTSD.

We are anticipating publication of the findings of the Columbia University and American Legion Vietnam Veterans Study in the near future; and we are confident that they, too, will shed important information on the relationship between combat stress and PTSD intensity for cohorts with differing intervals since the experience of the combat trauma.

The American Legion continues to be concerned, as we have advised this committee several times in the past, about the effects that DRGs are having on the treatment of PTSD, particularly in the inpatient treatment units and not only with respect to the provision of treatment but the fact that the DRG formulas have served as a disincentive or a deterrent for medical centers to establish inpatient units.

That will finalize the summary of our testimony.

Mr. STEINBERG. Thank you very much for your willingness to summarize. Your full statement will, of course, appear in the record. Jim Magill for the Veterans of Foreign Wars?

[The prepared statement of Mr. Sommer appears on p. 522.]

STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MAGILL. Thank you. I also will be extremely brief in that we have had extensive talks on this topic this morning and this afternoon.

In preparing for this statement, as I indicated in my prepared statement, we surveyed our field reps across the United States; and what we found out is that there does exist a lack of uniformity among the regional offices as to the disposition of claims. Where one regional office could be quite liberal, another one would be not so liberal in the adjudication.

Also, we discovered that the degree of disability awarded also varies between one regional office and another. The VFW strongly believes the VA should attempt to be more uniform in its guidelines in awarding PTSD claims. We believe this can be accomplished through better coordination between and within the various components of DM&S and increased education of the contract psychiatrist.

With respect to inpatient/outpatient treatment, the VFW is concerned about the quality of care being provided veterans suffering from PTSD. Our concerns are based on the fact that proper funding has not been provided, resulting in staff reductions and, of utmost concern, program curtailment.

Treatment programs that were originally 6 months in length are now maybe 60 days and, in some cases, have been reduced to only 18 to 20 days in length. This cutback in treatment can only serve to harm the veteran rather than help him.

One of the major hurdles in the treatment of PTSD is the recognition that treatment is needed. Once into the program, the veteran must be allowed to complete a full course of therapy.

Furthermore, relapses increase drastically when program time is reduced. Information available to the VFW indicates that the relapse rate went up 30 percent on the 28-day program and almost 80 percent when that program was reduced to 21 days.

In closing, much work needs to be done in fully addressing PTSD. Not only must we educate ourselves to understanding the complexities of this disability, but we must commit ourselves to fully fund, staff, and train those responsible for providing treatment.

That concludes my statement.

Mr. STEINBERG. Thank you very much, Jim. We will now hear from Mr. Gordon Mansfield of the Paralyzed Veterans of America. Gordon, we welcome you. We have not had the pleasure of your appearing before us on many occasions, and we are delighted to have you with us.

[The prepared statement of Mr. Magill appears on p. 538.]

STATEMENT OF GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Mr. MANSFIELD. Thank you, Mr. Chairman. One of the reasons I am here is that, in reviewing PVA's testimony, this issue was the first one I dealt with when I first came to Washington 7½ years ago; and I would like to thank the chairman and the members of the committee for the fact that we are now talking about how we do it, rather than whether we are going to do it or not.

Mr. STEINBERG. It was just about the first one I dealt with when I first came to the Hill 19½ years ago. [Laughter.]

Mr. MANSFIELD. And it goes on and on. As I say, I am pleased though that we are talking about how it is done and not whether we are going to do it or not. I, too, would like to summarize my statement.

As I said, the first thing is a thank you to the chairman and the members of the committee for the action they have taken on this issue and the fact that you are having an oversight so that we do continue to talk about how and not why.

Regarding the area of expansion; PVA fully supports expansion of eligibility for readjustment counseling services to allow access and treatment to veterans of all wars or designated armed conflicts; and we have discussed this in previous testimonies.

As well, VA health-care centers are being asked to provide more care and appreciably more complicated forms of care with fewer resources. Funding levels for the program at $40.5 million have remained constant for the past 3 years. To absorb this shortfall, we understand even to cover nominally increasing costs, the program has had to borrow and transfer funds from its contract care operations. In fiscal year 1987, these funds were set at $5.5 million; in 1989, we are looking at approximately $5 million. That is half a million down, plus they are still borrowing.

We feel that the contract program, as has been indicated in testimony here this morning, is important; and adequate funding should be provided so they can carry out their full mission.

We would also like to emphasize that the reestablishment of the National Center for Stress Recovery, which is supposed to be a center for excellence in treatment, training, and research, is a priority; and we think that should be followed up on in a timely manner.

We would also like to point out and commend Colonel Rheault, Outward Bound, and the VA for implementing the innovative concept of the Outward Bound Program. PVA was pleased to have coordinated some significant support for this program through the Welcome Home project.

The results seem to be encouraging, and PVA is funding a comprehensive outcome study of the results of the program that we have initiated through that funding. We will be happy to provide this committee and others copies of that upon its completion.

Mr. STEINBERG. Please do.

Mr. MANSFIELD. We would also like to reinforce the need for the continuation of CMD's special committee, and we would like to emphasize that we think there should be reinstated and required a continuation of reports from that committee and that the reporting element not be dropped.

As a final point, Mr. Chief Counsel, I sincerely hope that you are going to order extra copies of this hearing to be printed. I think they will be very useful to me as I pursue the issues of the VA budget in the future.

And as a final point, I think that the comments of DVB and DM&S personnel here on the issue of the veterans' claims procedure and what they are doing and are not doing are further evidence of the need for judicial review. And I look forward to using some information we have gained here this morning as we move into the House area to get that legislation passed. Thank you very much.

Mr. STEINBERG. Thank you, Gordon, for your very succinct comments this morning and for the very gracious remarks contained in your prepared testimony, as well as the testimony you have just given.

[The prepared statement of Mr. Mansfield appears on p. 542.]

Mr. STEINBERG. If any of the organizations are interested in our printing extra copies of this hearing, make us aware of your specific needs in that regard; and we will certainly do our best to make sure that we satisfy any of your demands.

Mr. **Mansfield**. To start with, 435, please.

Mr. **Steinberg**. All right. The other organizations certainly have plenty of time to get their requests in to us since, as you know, historically we don't exactly have a 24-hour turnaround in the printing of our hearings. [Laughter.]

And given the length of this one, I would think that this will be even somewhat longer than usual; but we appreciate your interest in having that, and that is why we have the hearings. We are delighted that you found it valuable this morning.

Next, we would like to hear from Mr. Thomas Sherwood, national director of health policy and planning, accompanied by Mr. Steve Bentley, national chairman of the VVA's special committee on PTSD and substance abuse, both representing the Vietnam Veterans of America. Mr. Sherwood?

STATEMENT OF THOMAS A. SHERWOOD, NATIONAL DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA, ACCOMPANIED BY STEVE BENTLEY, NATIONAL CHAIRMAN, VIETNAM VETERANS OF AMERICA SPECIAL COMMITTEE ON PTSD AND SUBSTANCE ABUSE

Mr. **Sherwood**. Thank you, Mr. Chief Counsel. Allow me to introduce Mr. Steve Bentley, who is the chairman of the Special Committee on PTSD and Substance Abuse for VVA; and he will give you the statement.

Mr. **Steinberg**. We are delighted to have you with us.

Mr. **Bentley**. Thank you.

Mr. **Steinberg**. Please proceed.

Mr. **Bentley**. I, too, will be brief summarizing the highlights of our report. The emerging full recognition of the ravages of PTSD has produced a real challenge to the VA in providing care for those veterans who are affected. Vietnam Veterans of America has identified the following aspects of PTSD care as sources of concern which the VA and the committee need to address.

First, funding for the readjustment counseling service vet centers. There is $42 million allocated for this program. Because of inflation and increased salaries for the staff in 189 vet centers, the original amount of contract dollars available for community counseling has fallen from as high as $8 million to $5 million and is still declining.

Valuable services being provided to our veterans on a contractual basis are being cut at the expense of larger budget of a program which is equally as important. We strongly recommend that VA's RCS budget at least match the real dollars lost through salary adjustment and inflation over the last 3 years.

Our second item is contract halfway houses for PTSD, an initiative that the VA can be proud of. However, what we have found is that these programs funded through VAMC resources are highly vulnerable when budget cuts in individual VAMC's are ordered up.

We urge the committee to foster stability in the funding of these programs so as to allow continuity of services over time.

On the PTSD programs, which we have heard so much about here today, currently there appear to be about 16 inpatient PTSD units throughout the VA involving approximately 500 beds. The

VVA is concerned about the considerable variability among these programs, especially with regard to the great variabilities in lengths of stay, lack of personnel assigned to these programs, lack of clinical and management organization in a few of these programs, and the need for these programs to clarify goals and objectives. It is apparent to us that basic standardization in the form of assessment, diagnosis, screening, admission, treatment, and discharge protocols should be developed.

FTEE in each VA medical center to serve in PTSD training and awareness capacity should be seriously considered. The incarcerated veteran continues to be overlooked. As veterans, these individuals may be in just as great or greater need of PTSD counseling as any other veteran.

We urge the committee to carefully consider the merits of a VA policy including the following:

Regular VA outreach assistance to penal facilities for the purpose of assisting these institutions and the veterans in them with PTSD, substance abuse, family and readjustment counseling; assistance in sensitizing prison staff as to the symptoms and behavioral problems likely to appear in veterans with PTSD; assistance in developing postprison strategies as a policy for incarcerated veterans, including vocational rehabilitation and education; assistance in developing an accurate data base on incarcerated veterans.

Then we have substance abuse and PTSD. We feel there is a strong correlation between alcohol- and drug-related problems and the symptoms of PTSD as they are experienced by Vietnam veterans. This correlation and its negative impact and effective treatment outcome and successful readjustment from any combat veterans has generally not been recognized, either in clinical literature or in treatment programs utilized by veterans.

Treatment programs for Vietnam veterans suffering from PTSD and chemical dependency, which address only one of these conditions, ignoring or minimizing attention to the other, are often doomed to failure. Even as more and more experienced professionals are recognizing the insidious relationship between PTSD and substance abuse, to date there has been no concerted effort at dealing with these dual manifestations and their far-reaching and tragic consequences.

There is presently on consistent consensus of how to approach this void anywhere within the existing system of PTSD units in vet centers and the VA.

The tragedy is that we can fill trailer trucks with the knowledge we have on PTSD as well as what is known about alcoholism and drug addiction; however, the research done on the two as they combine would fit into the glove compartment of the car.

One negative dynamic is that the two treatment modalities are in professional and financial competition with each other; and so, we not only have a dual diagnosis problem, we are having a dueling diagnosis problem.

We have turf battles in which the veteran is the loser. Alcohol treatment that denies a veteran his or her experience of Vietnam is unpardonable. By the same token, any program that hopes to treat PTSD must be equipped to deal with the condition of continued substance abuse.

We recommend more research specifically tailored to the mutually exacerbating relationship of PTSD and substance abuse.

And in the meantime, we feel the VA must provide treatment in PTSD care units for both PTSD and substance abuse simultaneously. Thank you.

Mr. STEINBERG. Thank you very much, Mr. Bentley. We will now hear from Chuck Williams, representing the American Ex-Prisoners of War and their national commander, Mr. Albert J. Bland. Mr. Williams.

[The prepared statement of Mr. Sherwood and Mr. Bentley appears on p. 555.]

STATEMENT OF CHARLES M. WILLIAMS, EXECUTIVE DIRECTOR, AMERICAN EX-PRISONERS OF WAR

Mr. WILLIAMS. Thank you, Mr. Steinberg. The American Ex-Prisoners of War are very grateful for the opportunity to appear here today and testify on post-traumatic stress disorder. Mr. Bland is getting ready for surgery in the morning and unfortunately could not be with us. I, too, will try to summarize.

It is an interesting coincidence that the committee selected July 14 for this important hearing. As you know, this is also Bastille Day; it is a day that is celebrated by the French for liberating thousands of citizens who suffered extreme and prolonged trauma during their confinement by the French monarchy. Long-term consequences were never assessed, but few could deny they persisted.

They weren't called post-traumatic stress disorder then, but that is what it was. Similarly, we have appended an informative article on prison ships during the American Revolution. Originally published in the DAR magazine in 1956, it details in stark language the brutal trauma inflicted on our first patriots.

Again, the long-term consequences were never assessed, but few could deny that they persisted. That wasn't called post-traumatic stress disorder either.

The background puts in better focus the tragic fact that those who bore the battle in all of our wars have always paid an extreme price in enduring the psychological damage to their minds, in addition to any physical damage to their bodies.

Understanding the scope and nature of the psychological damage and its persistence throughout later life has only begun to be understood in recent years. There is much more to be learned.

I was especially glad to hear Dr. Steven Sonnenberg confirm that fact earlier in the day. Trauma does leave a mark, and it is an enduring mark. It is not something that is cured in our belief; it is only kept under control.

Post-traumatic stress disorder is a specific pattern of psychiatric symptoms that characterizes many veterans of the Vietnam conflict, but is by no means a disorder restricted to that war.

We note with deep appreciation to the Veterans' Administration that all former prisoners of war have been specifically invited to participate in VA outreach centers. Indeed, many VA medical facilities have also established special groups where POW's can attempt to work through their still intense traumatic residuals suffered more than 40 years ago.

The first we are making is to reinforce the fact that traumatic residuals remain a major, lifelong problem. They don't fade away.

Our second point is that research, as well as anecdotal material, indicates suppressed anxiety from earlier combat experiences often resurfaces much later in life as coping skills of individuals gradually diminish due to health and living problems associated with aging.

We are convinced that readily available assistance to older veterans experiencing post-traumatic stress disorder like delayed reactions can serve an important preventative function in the sense of limiting the disrupting impact of such delayed stress reactions, both on the veteran and the family members.

The bottom line objective is to enable those veterans to develop additional stress management skills to replace or rebuttress those that are failing during their later life. This is a worthwhile challenge to VA in service to veterans who served their country so well on battlefields everywhere.

Mr. Steinberg, thank you very much.

Mr. STEINBERG. Thank you very much, Mr. Williams. We appreciate your testimony and your appearance here this morning; and would you please extend to your national commander our best wishes for a successful outcome tomorrow morning?

Mr. WILLIAMS. Thank you. I will, sir.

[The prepared statement of Mr. Williams appears on p. 566.]

Mr. STEINBERG. Our final witness on this panel and for the afternoon is Mr. Ray Field, who is the chairperson of the Veterans' Administration Advisory Committee on Native Americans and Native Hawaiians. We welcome you, Mr. Field. I believe this is your first appearance before the committee; and we are delighted to have you with us.

Let me note that I believe you do not have a prepared statement, but we certainly want you to have the opportunity to have a prepared statement printed in the record. You certainly have the opportunity to submit more than you will be allowed in the 5 minutes this afternoon.

So, please feel free to get a statement to us in a week or so, and we will be glad to print that in full.

Mr. FIELD. Thank you very much. I do appreciate that offer.

Mr. STEINBERG. Please proceed.

STATEMENT OF RAY FIELD, CHAIRPERSON, VETERANS' ADMINISTRATION ADVISORY COMMITTEE ON NATIVE AMERICANS AND NATIVE HAWAIIANS

Mr. FIELD. Mr. Chief Counsel, our committee has met four times, and we had intended to meet in Anchorage, AK, as you are aware. It seemed there was doubt as to whether we would be permitted to meet in Anchorage, AK.

We selected Anchorage, AK, because there are 300 Aleut and Native villages in Alaska and, because of the geographic remoteness, there is a pronounced lack of attention given to veterans' issues.

I want to express on behalf of all the committee a thank you to Senator Cranston, Senator Matsunaga, and Senator Murkowski for their immediate and gracious response and support. We will now be meeting in Anchorage, AK, on September 20-22, 1988.

Mr. STEINBERG. You are most welcome, on behalf of all of those members, and we were glad to assist Senator Matsunaga and Senator Murkowski in being of assistance to you.

Mr. FIELD. First, I would like to cite some pertinent numbers because there are such few assessment numbers that are available when determining the needs of native Americans and native Hawaiians.

There are not any particular studies that have broken out these two groups as target populations to be studied. The Research Triangle Institute Study did not include native Hawaiians or native Americans as target populations.

Thus, the magnitude of the problem is not available to the Senate Veterans' Affairs Committee, but there are some numbers that I would like to share with you.

During Vietnam, there were 42,000 native American veterans who served in country in Vietnam. One out of four of Indian males are veterans; 75 percent of those who went to Vietnam were volunteer enlistments. This is a cite from Dr. Robin LaDue, a clinical psychologist and a member of our committee.

During the military service, we had to suffer, I think, a disproportionate or unnecessary amount of pressure. There were terms that were used prior to that on reservations against us; interestingly, they were also used in the military. Dr. Tom Holm, a professor at the University of Arizona and a member of our committee, identified the commonly used terms as "chief," "redskin," and "blanket ass."

In his survey, Dr. Holm found that 100 percent of the respondents underwent those terms during their military experience. And of the terms for Hawaiians, "pineapple" comes to me most strongly because I heard that very often applied to Hawaiian soldiers.

As far as how we address PTSD, we didn't know then, of course, what PTSD is; but we do have some native American ceremonies among the many tribes which helped prepare us as we departed to Vietnam. There are tribal ceremonies to prepare the warrior to fight because he is there to fulfill his role as a warrior: to protect all his relations and the land.

Dr. Holm reported 49 percent of the Indians who returned did participate in a ceremony—a cleansing ceremony—on return to the reservation. That was, I think, largely responsible for the good feelings our veterans had on returning to their people.

The problem arises, and it becomes a multiplier fact, when the Indian goes out to the mainstream of society. The Vietnam veteran is considered by most clinicians as somewhat testy, cautious, and angry. Then, when that Vietnam veteran is a native American or Hawaiian, many times the VA counselors apply those same adjectives in describing the native American or the native Hawaiian's point of view.

So, it becomes more complicated. What we respectfully submit is that these two groups and other groups, too, that are not target populations should have a particular study accomplished enabling a fairer allocation of Federal resources to those deserving it.

There is a need, we feel, in our report to the Congress——

Mr. STEINBERG. I am going to ask you to conclude shortly since your 5 minutes are almost up.

Mr. FIELD. I am sorry.

Mr. STEINBERG. Please try to conclude your remarks.

Mr. FIELD. We do urge that there be some means by which we have influence on policy within the Veterans' Administration because sensitization must occur with counselors; sensitization must occur with policymakers. And that is sort of from the bottom to the top in the Veterans' Administration. I will let that conclude my remarks.

Mr. STEINBERG. Thank you very much. I might comment that we had hoped that the establishment of the advisory committee would provide such a forum and a voice for native Americans and native Hawaiians with respect to the VA. We hope that you will continue to make your views known.

We have in the public law enacted on May 20 extended your committee for approximately an additional year to submit another report, and we will be looking forward to getting that. I might also note that the bill that was referred to earlier, S. 2011, reported by this committee on June 29, does have in it a provision authored by Senator Matsunaga requiring that a PTSD study be carried out in a statistically valid way of the populations of native Americans, American Samoans, native Hawaiians, and others who were not included in sufficient numbers in the RTI study which was reported on this morning.

So, I hope that we are anticipating your testimony and some of the needs that you have outlined this afternoon.

I would like to ask each of you if you would like to share with us any brief perspectives that you have on the hearing that took place today, on any particular points that occurred in the various exchanges that we had that you think need underlining or clarification or amplification.

I would start with Gordon and then just work down the table. And if you wish, of course you may also respond in writing with any further comments that you have or in lieu of responding at this particular time.

Mr. MANSFIELD. In the interest of time, Mr. Chief Counsel, I think that with our submitted statement and those highlights that I covered, we may take advantage of your offer and submit anything following in writing.

Mr. STEINBERG. Fine. John?

Mr. SOMMER. Just a few brief comments, Jon. There are a few things, I think, that need have some emphasis placed on them. One thing that appears to me to be very important is the disparity in the rates between the CDC and the RTI studies with respect to the amount of PTSD in the Vietnam population.

Another thing which I mentioned in the summary is the importance of the DRG's. We understand that there is some work being done; they are taking a look at it. However, this is long overdue, and we believe it is creating a lot of problems.

Dr. Friedman mentioned that there are limitations on resources that are provided for VA treatment of post-traumatic stress disorder, and we feel that that is a very important issue. This issue has been mentioned several years in the past, during the appropriations process, when no specific funding was provided for the development of additional inpatient PTSD units or any other provision of treatment.

I will conclude my comments with that.

Mr. STEINBERG. As you know, we will be getting further amplification from both CDC and RTI, as well as the VA, on those questions. Mr. Bentley.

Mr. BENTLEY. A couple of things. The VVA has put together a national committee made up of 16 experienced professionals who have experience both in the area of substance abuse and Vietnam readjustment. And we have some very prominent consultants—experts on PTSD—that include Dr. Matthew Friedman; and we will be having a conference in August.

I will certainly get the report of that and what comes about when we get together to you.

Mr. STEINBERG. The committee would like to have that. Thank you.

Mr. BENTLEY. I would just like to reiterate something that I have heard up here today regarding the attitude toward these numbers and how many there really are and so forth. It seems to me that I heard someone once define maturity as "the ability to deal with ambiguity or conflicting facts."

At this particular point, I feel like it is certainly true that a great many Vietnam veterans are leading full and productive lives but the amount that are suffering doesn't really matter. I think that it is time that we get down to the business of helping these people help themselves.

One of the things that I certainly notice in looking at both substance abuse and PTSD is that they say that every alcoholic touches four others significantly in his life; applying the same ratio to Vietnam veterans, we are talking about very, very high numbers.

The families were mentioned here today; but again, it is something that is too often overlooked. We need holistic, broad-based therapy that takes in the whole family unit.

Mr. STEINBERG. Thank you very much. Mr. Field, do you have any comments that you wish to share with us on any of the proceedings earlier today.

Mr. FIELD. It is more of a question. Mr. Don Shasteen, the Assistant Secretary of Labor for Employment and Training, has informed me that they will be issuing RFP's on contracts to study hardcore unemployed veterans. When PTSD occurs substantially with a person, undoubtedly his employment status changes; and with the employment status, the status of his family, the nutrition that they get is affected similarly.

I was wondering how in legislation considered by this committee would be integrated with the research of mental effects of PTSD to the problems high unemployment attendant to PTSD victims. That was just a question.

Mr. STEINBERG. I guess there are several answers. Although we have many experts at the table down there who could probably answer better than I, to the extent that you have a service-connected PTSD rating at 10 percent or more, that individual is eligible for vocational rehabilitation from the Veterans' Administration.

And I am sure there are indeed quite a number of individuals with PTSD who have taken advantage of that.

In addition, you do have eligibility on the part of Vietnam era and Korean conflict veterans for job training under the Veterans' Job Training Act. Although there is not a great deal of money remaining in that act, our understanding is that there are sufficient resources and reallocation of resources available to continue through the end of this fiscal year.

We do have, obviously, the Veterans' Employment and Training Service referral and counseling and guidance services. You have the operation of the DVOPS [the Disabled Veterans' Outreach Program Specialists] who are dedicated to providing job opportunities and counseling for service-connected veterans.

So, I feel that there are in place a wide number of programs that can be an advantage to veterans with PTSD. We also have, to the extent that there are homeless veterans with PTSD, a special homeless veterans program that is a result of legislation authored by Senators Murkowski and Cranston that is funded at about $2 million.

And there are a number of such community-based projects around the United States to assist in that area.

So, our hope is that there are a number of programs in place can be of assistance with employment problems for veterans with post-traumatic stress disorder. And there is no doubt that employment would be a substantial problem for many such individuals.

Again, on behalf of the chairman and the ranking minority member and all the members of the committee, we thank you all very much for bearing with us for such an extended day. It was certainly not our anticipation that it would be quite so extended; but you have been most gracious, and we appreciate it very much.

Tom, do you have any comments or questions at this point.

Mr. ROBERTS. Thanks, Jon. Just one comment, particularly for our last panel. On behalf of the minority, I certainly want to thank you for staying with us all day. I think it is extremely important that this committee get the benefit of the nongovernmental point of view, and we certainly do appreciate your staying around and giving us your views.

Also, Mr. Field, Senator Murkowski certainly appreciates your persistence on this issue, which is of course extremely important to his State of Alaska. Thank you.

Mr. FIELD. Thank you.

Mr. STEINBERG. Finally, I thank our most courageous reporter for bearing with us throughout this long proceeding. We thank all of those in the audience.

This hearing stands adjourned.

[Whereupon, at 4:05 p.m., the hearing was adjourned.]

APPENDIX

STATEMENT FOR VETERANS HEARING ON POST-TRAUMATIC STRESS DISORDER
SENATOR JOHN D. ROCKEFELLER IV
July 13, 1988

Mr. Chairman, I come to this hearing with a great deal of interest. Of course, the issues surrounding post traumatic stress disorder are by no means new. You, Mr. Chairman, have been working for years and years with other members of this Committee, as well as our colleagues in both bodies of Congress, to determine the extent of psychological problems among Vietnam veterans and to respond with appropriate action.

My own state of West Virginia serves as a microcosm of the problems and observations that appear in the testimony for today's hearing. West Virginia suffered the highest combat casualty rate in Vietnam than any other state. Our boys were put in the front lines, and died in disproportionate numbers for their duty. And it is very clear that those who were fortunate to return home have brought with them wounds and scars and effects that still linger with them.

Of the 67,000 Vietnam veterans in West Virginia, over 29,000 were in combat. Experts say at least 7,000 of these 29,000 are suffering from PTSD. As one counselor in a Vet Center told me, these are men who have been literally invaded by this disorder. It has affected their ability to work, to hold onto their marriages, and to function in the most basic way.

Today, we will again hear in no uncertain terms that PTSD is a serious disease among Vietnam veterans. In my view, we have the definitive evidence to justify responding more aggressively, compassionately, and effectively to this problem.

Again, I refer to my state. We have four VA hospitals in West Virginia. Not one of them has a special PTSD unit equipped specifically to serve veterans with this disorder -- a disease that by definition is service-connected and that we are learning may affect 15 percent of Vietnam veterans. When a Vet Center counselor, for example, recognizes that a veteran in West Virginia has a level of PTSD that requires inpatient treatment, he may have to work for months or even years to get that veteran admitted into a mental health program with the relevant expertise and resources. And for the veteran in West Virginia, he will have to travel to a VA hospital hundreds of miles away, in another state, to get that treatment.

It appears that a range of efforts need to be considered to improve the VA system for addressing PTSD. Outreach and education have to be stepped up. Vet Centers should be retained and given direction, information, and resources to provide the best possible services. And in particular, the VA health care system has to make a commitment to increasing access and the quality of mental health and related services -- inpatient, outpatient, and in other forms -- for veterans with PTSD.

I recognize that this takes resources. I also should note that this committee has even very recently approved several measures that are directed at improving services for Vietnam veterans in this area. It is clearly time for the VA to reconsider its priorities and to have the will to meet a vastly unmet need. We must respond to the pain and suffering of PTSD. The toll on society will continue to be enormous unless major, major action is taken to help veterans whom we truly owe our respect, gratitude, and compassion.

STATEMENT OF SENATOR FRANK H. MURKOWSKI (R-AK)

COMMITTEE ON VETERANS' AFFAIRS HEARING - JULY 14, 1988

Good morning and welcome. It is a pleasure to welcome the many witnesses scheduled to testify this morning on issues related to Post-Traumatic Stress Disorder. I commend you, Mr. Chairman, for holding this important hearing.

I realize that we have a very full agenda and list of witnesses, so I will make my comments brief. First, I believe that the VA is doing a commendable job of providing treatment for veterans with PTSD. The VA has implemented a variety of treatment modalities and approaches -- including Vet Center counseling, special inpatient PTSD units, and mental hygiene clinics -- which are designed to provide an appropriate level of care for these veterans. Perhaps more needs to be done. We shall learn more about that today.

Second, I believe it is very unfortunate that the media, and even some members of Congress, appear to be making a habit of either reporting false or distorting information about Vietnam veterans. The perception that many have of Vietnam veterans is simply inaccurate. I am offended by articles and television programs which portray Vietnam veterans as maladjusted, angry, drug and alcohol abusing, unemployed and unemployable losers.

There are simply no studies or data to support these negative assertions. Although they may be well intended, these negative images do a great disservice to Vietnam veterans and their families.

For the record, let me state the plain truth about Vietnam veterans. The Centers for Disease Control (CDC) recently completed a study which compared veterans who served in Vietnam with veterans who served in other locations during the same time frame. CDC found that the groups were similar in level of education, employment, income, marital status, and satisfaction with relationships. In fact, the unemployment rate for Vietnam-era veterans in June 1988 is 3.3 percent. This is .5 percent lower than non-veterans.

Further, only 2 percent of the Vietnam veterans were found to have met the criteria for a PTSD diagnosis during the month prior to their medical exams. Expanded to the entire Vietnam veteran population, it would indicate that about 60,000 veterans have PTSD. Let me be clear, veterans with a PTSD diagnosis are not generally institutionalized on a psychiatric ward or otherwise incapacitated. They are often functioning and productive members of society. And PTSD is not associated solely with Vietnam veterans as is often discussed. Individuals who experience a traumatic event -- such as a natural disaster or airplane crash -- may have flashbacks and nightmares. Regardless of the prevalence of PTSD among veterans of any war, the VA must remain responsive to these veterans. Appropriate treatment is necessary, and I believe that the VA is also committed to that objective.

In closing I would like to commend Butch Joeckel, the National Adjutant of the Disabled American Veterans, for his outstanding article which appeared in the July 1988 issue of the DAV Magazine. Butch also discussed the negative stereotype associated with Vietnam veterans in a very articulate manner. I would recommend his article to those present today.

I look forward to learning the views of VA policymakers, clinicians, and researchers all who have extensive knowledge about PTSD.

Thank you, Mr. Chairman.

OPENING STATEMENT: PTSD OVERSIGHT HEARING

BY SENATOR SPARK M. MATSUNAGA
Senate Veterans' Affairs Committee
628 Dirksen Office Building
July 14, 1988

At the outset, I wish to commend the Chairman of the Committee for his initiative in scheduling hearings on this important issue. He continues to set the moral standard for the nation in his concern for veterans suffering from readjustment difficulties, particularly those who manifest PTSD, one of the most serious psychological disorders that is often associated with military conflict. Without his leadership on this issue, without his strong support for community-based Veterans Readjustment Counseling Centers and his perpetual fight for adequate health care resources, the problem posed by PTSD would be far, far worse than it is.

I join the Chairman and other members of this Committee in renewing my commitment to providing whatever is necessary to care for all veterans suffering from PTSD, as well to obtaining a better understanding of the disorder itself.

In closing, let me welcome the many distinguished witnesses who are with us today. In particular, I wish to welcome Dr. Roger Hamada, a VA psychologist from Hawaii who flew out here on short notice to testify on the effects of PTSD on veterans of Asian descent. Welcome, everyone; I look forward to your testimony.

# # #

STATEMENT
Senator George J. Mitchell
Committee on Veterans' Affairs
July 14, 1988

Mr. Chairman, I'm pleased to be here this morning with you and the other members of the Committee to receive testimony on the current efforts within the Veterans Administration to deal with Post-traumatic Stress Disorder.

First of all, Mr. Chairman, I commend you for holding this hearing. Doing so is consistent with your long-standing efforts for the VA to identify, counsel and assist Vietnam veterans suffering psychological problems associated with their military service.

Today's hearing will also include testimony regarding two recent studies on the health status and psychosocial characteristics of Vietnam veterans and veterans who did not serve in Southeast Asia:

The "Vietnam Experience Study," conducted by the Centers for Disease Control (CDC) and
the preliminary fndings of the "national Survey of the Vietnam Generation and National Vietnam Readjustment Study" conducted by the Research Triangle Institute.

Since 1980, the American Psychiatric Association officially recognized PTSD as a diagnosable psychiatric disease. That same year, the VA added PTSD to its rating schedule and also opened the first Vet Centers.

Mr. Chairman, eight years later, there is still considerable controversy and uncertainty regarding the progress that has been made by the VA in coming to grips with this disability and providing effective counseling and other treatment to those veterans who suffer from the various symptoms of PTSD.

I can make that statement with no reservation after chairing, with my colleague Bill Cohen, two separate hearings on PTSD in my state.

I've held many public meetings and hearings in my state since coming to the U.S. Senate. With the possible exception of the hearings held in connection with the proposal to locate a high-level nuclear waste dump in Maine, no subject generated more passion, more emotion and stories of real emotional pain than those two hearings.

So I look forward to the testimony this morning. I especially wish to point out that the Committee is graced this morning with three witnesses from Maine.

Bob Rheault, works with the Hurrican Island Outward Bound Program in Rockland, Maine. That program works with the PTSD unit at the Northampton, Massachusetts, VA medical Center.

Bob Comeau, who is the Team Leader of the Portland, Maine, Vet Center. Bob has been at the Vet Center almost from the day it opened its doors.

Steve Bentley, who is the National Chairman of the Vietnam Veterans of America's Special Committee on PTSD and Substance Abuse. Steve was an important witness at both hearings on PTSD I chaired in Maine.

I regret that I will be unable to attend all of today's hearings. But I will review all of the testimony carefully. I look forward to working with you Mr. Chairman and our distinguished ranking member on this issues in the coming weeks.

NATIONAL VIETNAM VETERANS READJUSTMENT STUDY

Research Triangle Institute

NATIONAL VIETNAM VETERANS READJUSTMENT STUDY (NVVRS):

DESCRIPTION, CURRENT STATUS, AND INITIAL PTSD PREVALENCE ESTIMATES

Submitted to the U.S. Senate Committee on Veterans' Affairs
as Testimony for the Oversight Hearing on
Post-Traumatic Stress Disorder

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July 14, 1988

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REFERENCES

I. OVERVIEW

A. Purpose

This document has been prepared in response to Senator Alan Cranston's letter of June 24, 1988, inviting the research team of the National Vietnam Veterans Readjustment Study (NVVRS) to prepare and present testimony for an oversight hearing on Post-Traumatic Stress Disorder (PTSD) to be held by the U.S. Senate Committee on Veterans' Affairs on July 14, 1988. As requested in that letter and in conversations with Committee staff, this written testimony consists of five elements: (1) a brief overview of the background and objectives of the NVVRS, and a detailed summary of the NVVRS study design; (2) a description of the current timetable and costs of this research project; (3) a description of the criteria and methods used to assess PTSD in the NVVRS; (4) a presentation the first estimates of the prevalence of PTSD based on these methods; and (5) a comparison of the NVVRS estimates with those recently presented by the Centers for Disease Control based on their Vietnam Experience Study, including a discussion of differences in criteria, samples, and methods used to assess PTSD in both studies. Additional technical details are provided in five appendices.

B. Background

With the evacuation of Saigon on March 25, 1973, the role of overt American intervention in the Republic of Vietnam was terminated, and on May 7, 1975, President Gerald R. Ford proclaimed an end to the "Vietnam era." By September 30, 1983, an estimated 8,238,000 men and women who served in the U.S. Armed Forces (both in the Vietnam theater and elsewhere) during the Vietnam era (which officially began on August 5, 1964) had returned to civilian life (U.S. Veterans Administration, 1983). During the thirteen years since the Ford proclamation, the Nation has hotly debated the nature and extent of the problems faced by these Vietnam-era veterans in readjusting to civilian life. Hundreds of articles and dozens of books concerning Vietnam veterans' readjustment to civilian life have been published, and the plight of these veterans has been a popular theme in the news media, television, and the movies. In part, this increasing public interest in the Vietnam war and its veterans reflects some dramatic and precedent-setting changes in the country's socioemotional climate in recent years, changes that have gradually depoliticized somewhat the debate over the mental health of Vietnam veterans.

It is also clear, however, that at least for a significant minority of the men and women who served during the Vietnam war, "the war is not yet over," in that they continue to suffer from emotional turmoil 15-20 years or more after the end of their military service and return to civilian life. Yet previous estimates of the actual numbers of veterans in need have varied widely, from as few as 250,000 (e.g., Wilson, 1978) to over 2 million (Egendorf, 1982). Thus, while there is general consensus that some Vietnam veterans suffer from PTSD and other psychological problems in readjusting to civilian life, precise national estimates of the number of Vietnam veterans experiencing such problems have simply not been available. Recognizing the critical need for such information, in the 1983 renewal of the VA's Readjustment Counseling Program (Public Law 98-160) the U.S. Congress mandated the conduct of a "study of the prevalence and incidence of post-traumatic stress disorder (PTSD) and other psychological problems in readjusting to civilian life" among Vietnam veterans. The study was to be of sufficient size, scope, complexity, and design to provide national estimates of the extent of Vietnam veterans' mental health and other health needs and to permit sophisticated analyses of the nature, scope, covariation, and etiology of their readjustment difficulties. On September 12, 1984, the Veterans Administration (VA) awarded a contract to the Research Triangle Institute (RTI) and its collaborators to conduct this mandated study, which came to be known as the National Vietnam Veterans Readjustment Study (NVVRS).

C. Study Objectives

The NVVRS has three broad goals, as mandated by the Congress and evolved by the VA, its consultants, and the research team (see Exhibit I-1). The first major goal of the study is to provide information

Exhibit I-1

Objectives

Conduct a Comprehensive Study in the Population of Vietnam Veterans (VVs)

I. PREVALENCE AND INCIDENCE OF:

    A. Post-Traumatic Stress Disorder (PTSD)
    B. Other Psychological Problems of Readjusting to Civilian Life--Other "Post-War Psychological Problems" (PWPPs)

        1. Other DSM-III Psychiatric Disorders
        2. Malfunctions in:

            A. Marital Roles
            B. Familial Roles
            C. Vocational Roles and Careers
            D. Educational Roles and Careers

        3. More General and Subjective Disturbances

            A. Life Satisfactions, Dissatisfaction, Quality of Life
            B. Demoralization or Non-Specific Distress

II. EFFECTS OF PWPPs ON SUCH VETERANS, ESPECIALLY:

    A. Those With Service-Connected Disabilities
    B. Women Veterans

III. ASSESS CORRELATIONS BETWEEN PTSD AND OTHER PWPPs:

    A. Physical Disabilities (By Type)
    B. Alcohol and Drug Abuse
    C. Minority Group Membership
    D. Incarceration in Penal Institutions

IV. EVALUATION OF LONG-TERM EFFECTS OF PWPPs ON:

    A. Families
    B. Others in Primary Social Relationships

V. EXTENT TO WHICH VVs WITH PWPPs USE VA AND OTHER RESOURCES

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about the incidence, prevalence, and effects of post-traumatic stress disorder and related post-war psychological problems among Vietnam veterans.

A second major goal of the study is to provide a comprehensive description of the total life adjustment of Vietnam theater veterans and to compare their adjustment to that of era veterans (i.e., persons who served in the Armed Forces during the Vietnam era but did not serve in the Vietnam theater) and nonveterans. It is intended that this description document in the aggregate the course of the lives of these three groups: the problems they have faced, the ways in which they have coped, and the quality of their lives. The description covers many dimensions of life--education, work, family, interpersonal relations, emotional stability, etc. The aim is to look at the broad spectrum of adjustment and to identify factors that have made both positive and negative contributions to these citizen's lives.

A third major goal of the study is to provide detailed scientific information about one specific type of post-war psychological problem: post-traumatic stress disorder (PTSD). Of particular interest are its antecedents, its course, its consequences, and its relationship to other physical and emotional disorders. Relationships between PTSD and other post-war psychological problems, physical disabilities, substance abuse, minority group membership, and criminal justice involvement are all to be examined. Additionally, information describing the impact of post-war psychological problems on veterans' families and on their use of VA facilities is to be developed. In short, nothing less was required than perhaps the most far reaching and ambitious national mental health epidemiological study ever attempted on any population.

D. Study Design

1. Overview of Major Components

Clearly, to achieve these broad and very ambitious objectives a rather extraordinary research design was needed, one requiring careful attention to sampling and location procedures, instrument development and validation, data collection, and numerous other special methodological issues. In addition, the controversial nature of some of the study's subject matter (e.g., PTSD), the intense interest in the study on the part of groups across the political spectrum, and the programmatic implications of the study's findings have all acted to underscore the importance of the design to the ultimate utility of the study's findings. If the findings are to be useful to policy makers, they must be credible to the scientific community, to various political interest groups, and ultimately to the Congress. As with all research projects, the credibility of the findings from the Readjustment Study is predicated on the rigor of its research design.

To meet the Readjustment Study's ambitious informational and methodological objectives, RTI proposed a design with multiple components. The component designed to meet the study's major informational objectives was the National Survey of the Vietnam Generation (NSVG). The NSVG research design involved indepth face-to-face interviewing averaging 3 to 5 hours in length with samples drawn to represent the study's three major groups of interest. These are: (1) Vietnam theater veterans--persons who served on active duty in the U.S. Armed Forces during the Vietnam era (August 5, 1964, through May 7, 1975) and who served in Vietnam, Laos, or Cambodia or their surrounding waters or airspace, (2) Vietnam era veterans--persons who served on active duty in the U.S. Armed Forces during the Vietnam era who did not serve in the Vietnam theater, and (3) nonveterans or civilian counterparts--persons who did not serve in the military during the Vietnam era, matched on age, sex, race/ethnicity, and (for women) occupation to the theater veterans. In order to assure that critical statistical comparisons could be made reliably, certain subgroups were oversampled. These included blacks, Hispanics, women, and theater veterans with service-connected disabilities.

The content of the survey interview was designed to cover the broad spectrum of adjustment, including such topics as marriage and family, education and occupation, military service and Vietnam experience, stressful and traumatic life experiences, substance use, psychiatric disorder, physical health, and use of health and mental health services. A summary outline of the topics covered and the average number of minutes of interview time allocated to each is shown in Exhibit I-2.

Exhibit I-2

National Vietnam Veterans Readjustment Study: "National Survey of the Vietnam Generation"-- Average Interview Times by Section for the Household Interview

Section/Title		Time in Minutes Vietnam Theatre Veterans	Vietnam Era Veterans	Civilian Counter-parts
SECTION A:	Preamble and Eligibility	2	2	2
SECTION C:	Marital History and Adjustment	10	10	10
SECTION D:	Parenting History and Adjustment	10	10	10
SECTION E:	Educational History	6	6	6
SECTION F:	Occupational History and Work Role Adjustment	9	9	9
SECTION G:	Childhood and Family History	12	12	12
SECTION H:	Military Service History	16	16	2
SECTION J:	Vietnam Experience	60	--	--
SECTION K:	Post-Service	22	22	--
SECTION M:	Stressful and Traumatic Life Events	22	18	10
SECTION N:	Self-Perceptions, Attitudes, and Nonspecific Distress	18	18	24
SECTION P:	Physical Health Status	9	9	9
SECTION R:	Diagnostic Interview Schedule (DIS)	79	73	72
SECTION S:	Use of Health and Mental Health Services	16	15	13
SECTION T:	Social Support	6	6	5
SECTION U:	Demographics	11	11	11
TOTALS		308	237	195
		5:08 Hrs.	3:57 Hrs.	3:15 Hrs.

Three additional components of the NVVRS that are closely related to the NSVG are also of key importance in meeting the study's objectives. These are a Preliminary Validation Study component conducted and analyzed prior to (and in preparation for) the NSVG, and the Clinical Interview and Spouse/Significant Other Interview components, both conducted subsequent to the NSVG interview.

Because at the time this study was initiated none of the measures currently available for a survey-based assessment of post-traumatic stress disorder had yet been validated, an integral part of the study design was the fielding of an elaborate Preliminary Validation Study component. Candidate PTSD measures were administered to 225 Vietnam theater veterans whose mental health status with regard to PTSD and other psychiatric disorders was known, who were identified by persons in the VA system. The purpose of this validation study was to determine how well diagnostic decisions about PTSD made on the basis of information collected in a survey interview would correspond with diagnostic decisions made by trained clinicians with extensive experience in the diagnosis and treatment of PTSD. This component served as the basis for selecting among candidate instruments to be used in the NSVG based on their demonstrated validity in diagnosing PTSD.

For the Clinical Interview component, a subset of over 300 theater veterans and 100 era veterans was selected to undergo a follow-up clinical interview with an expert mental health professional. This was a semi-structured diagnostic interview, and its purpose was to provide additional information about the validity of diagnoses made on the basis of information collected in the survey interview, in particular the validity of the diagnosis of PTSD. These interviews were conducted by mental health professionals located in 28 specific geographic areas around the country who are experienced in working with stress disorders. The Clinical Interview sample was drawn from among theater and era veteran respondents to the NSVG survey interview who lived within "reasonable commuting distance" of these 28 areas, and included all those who appeared on the basis of their survey interview to be PTSD positive, and a sample of those who appeared to be PTSD negative.

The Spouse/Significant Other component involved one-hour followup interviews with the spouses or other co-resident partners of over 450 theater veterans. The purpose of these interviews was to collect information about the veteran from a collateral, and to assess the impact of post-war psychological problems of Vietnam theater veterans on persons sharing their lives with these veterans. The Spouse/Significant Other subsample was selected from the entire theater veteran sample to include adequate numbers of both spouses or partners of veterans whose survey interviews suggested substantial levels of post-war psychological problems and spouses/partners of those without such problems.

2. Sample Design of the NSVG

Two important requirements in the design of the NSVG were (1) that the sample of persons interviewed be nationally representative of the corresponding populations, and (2) that adequate comparison groups be included to provide a context for understanding the current adjustment problems of Vietnam veterans. To meet these requirements, the NSVG design specified the selection of national probability samples of Vietnam (theater and era) veterans and their civilian counterparts of sufficient size to support estimates for and contrasts among the groups of interest. These contrasts include those for theater and era veterans (male and female), for theater veterans and nonveterans (male and female), for subgroups of theater veteran males (black, Hispanic, and white/others), and for Vietnam theater veterans exposed to different levels of combat or war zone stress.

To meet these requirements, the NSVG sample design combined (1) a military records based sample designed to yield 1,500 Vietnam theater veterans and 730 era veterans, (2) a household sample of 450 male and 50 (non-nurse) female civilian counterparts, and (3) a list sample of 150 female civilian registered nurses. The Vietnam theater veteran sample was augmented with 100 theater veterans with service-connected disabilities, for a total of 1,600 theater veterans.

For this study, the veteran respondent universe was defined as all persons who served on active duty in the military forces of the United States during the Vietnam era (August 5, 1964 through May 7, 1975), except those currently on active duty. Under this definition, career retirees, enlistment terminations, and persons who served on active duty during the

Vietnam-era and are now reservists or National Guard personnel are all included. By this definition the study population contains an estimated 93 to 94 percent of all living persons who served on active duty during the Vietnam era, the most comprehensive coverage of the Vietnam veteran population of any study conducted to date.

The task of selecting the veteran samples was complicated by the simple fact that there exists no master list of the over 8 million veterans who served during the Vietnam era. Consequently, one of the study's initial tasks was to create such a list (or sampling frame) from which the samples of veterans could be selected. The most common means for doing this in past studies was to screen households either by telephone or in-person to identify Vietnam era veterans. However, this approach necessarily relies on self or proxy reports to identify veterans, and the screening rates obtained by the most rigorous surveys employing this method (Fischer et al., 1980; Rothbart et al., 1982) suggest significant underreporting of Vietnam theater and era veteran status, resulting in undercoverage on the order of 32-38 percent relative to 1980 Census data. As a result, the NVVRS sampling frame for veterans was compiled from three different sources of military personnel records: (1) the National Personnel Records Center (NPRC); (2) the Defense Manpower Data Center (DMDC); and (3) a special list compiled for the VA by the Department of Defense's Environmental Support Group (ESG), reported to contain the names of all female theater veterans.

From a sample of 34,000 accession numbers selected from the NPRC Chronological Model (which includes accession numbers assigned to personnel records received between January, 1966, and June, 1977), 25,000 personnel records were fully abstracted, and a total of 966 cases were selected from the master data files at DMDC. These two sources served as the basis of the male theater and era veteran samples. These surveys were designed to include sufficient numbers of minority members to produce the required oversamples of blacks and Hispanics. While the number of black veterans available was sufficient for the black oversample, the number of Hispanics was insufficient to provide an adequate yield. Therefore, a supplemental sample of 6,800 accession numbers from NPRC was required to obtain adequate numbers of Hispanic male theater veterans to meet the statistical requirements of the study.

The NPRC and DMDC files were also the basis of the female era veteran sample. However, because more than 80 percent of women veterans serving in the Vietnam theater were nurses, the sample design for female Vietnam era veterans was modified to produce a similar proportion of nurses in that subsample to ensure more valid comparisons between these two groups. In order to obtain adequate numbers of era veteran nurses for that purpose, a sample of 205,000 accession numbers from the NPRC Chronological Model was screened for all potential female names. The military records for all those with potentially female names were retrieved and examined to determine gender, and all records verified as female were abstracted to identify nurses based on the recorded military occupational specialty (MOS). Finally, the female theater veteran sample was drawn from the ESG list of female theater veterans.

3. Implementation

While it may not be readily apparent from this brief description, the implementation of this complex, multiple component study design proved to be especially challenging; indeed, a formidable test of the hypothetical limits of survey research. For example, although identification of the veteran samples from military records provided the advantage of a more representative sample than could have been achieved through identification via household screening, it had the distinct disadvantage of requiring the research team to track down all sampled veterans wherever they may currently be living, in order to interview them. The resulting sample was scattered literally throughout the world, and tracing information from military records was often up to 20 years old. However, through an interagency agreement with the National Institute of Occupational Safety and Health (NIOSH), it was possible to obtain current addresses for most veterans from the Internal Revenue Service (IRS), with the remainder located by specialized tracing procedures. Even when located, the sample was very widely scattered, and interviews were conducted in virtually every corner of the 50 states and Puerto Rico. This resulted in an unusually high level of interviewer travel (averaging 200 miles and 7 hours per case for theater veterans), in conjunction with the administration of a highly sensitive interview averaging 3-5 hours in length. In turn, the complexity and sensitivity of the latter required 10 full days of training and a special certification procedure for over 140 interviewers.

In spite of these and some other unique and formidable challenges, the NVVRS was able to successfully achieve virtually every performance objective established for this landmark study. In the NSVG, it was possible to locate over 95 percent of the veterans sampled (over 96 percent of the theater and 93 percent of the era veterans). The 3,016 total interviews conducted exceeded the targeted number of 2,980. For Vietnam theater veterans, over 83 percent of those sampled and eligible (87 percent of those located and eligible) were interviewed, ranging from 81 percent among Hispanic male theater veterans to 86 percent for female theater veterans. Response rates for Vietnam era veterans and nonveterans were 76 and 70 percent, respectively, reflecting in part the lower salience of the survey to these groups in relation to the level of burden required for their participation. Similarly, 344 of the 403 Vietnam theater veterans selected for the Clinical Interview component (85%) were successfully interviewed, ranging from 80 percent among Hispanic males to 97 percent among women, as well as 95 of the 116 era veterans (82%). Of the 557 theater veterans selected for the spouse/significant other interview (for whom there was an eligible co-resident spouse or partner), 474 resulted in a completed interview, for an overall response rate of 85 percent--ranging from 83 percent for black and Hispanic males to 91 percent for the female theater veterans.

II. CURRENT STATUS OF THE NVVRS

A. Timetable

The Request for Proposals (RFP) to conduct the NVVRS specified a period of performance of 42 months, implying the delivery of a final report and executive summary to the VA in mid-March of 1988. In its proposal, however, RTI suggested that the field data collection period might be reduced from 15 to 12 months, allowing some additional time to evaluate Validation Study results and reducing the overall study timetable from 42 to 40 months. This proposal was accepted by the VA, with a starting date of September 12, 1984, and an implied ending date of approximately January 12, 1988. Currently, then, the project is approximately 6 months behind schedule, and the following timetable of remaining activities indicates a completion date approximately 10 months later than that specified in the original project schedule:

Activity	Original Proposal		Current Schedule	
	Start	Finish	Start	Finish
Advance Data Report (to VA)	02-15-86	06-15-86	03-18-87	08-15-87
Analysis of Full Study Sample and Preparation of Final Report	10-15-86	11-15-87	04-15-88	10-06-88
Presentation of Draft Analyses to the VA	--	04-15-87	--	08-15-88
Draft Final Report to the VA	--	11-15-87	--	10-06-88
Submission of Revised Final Report and Executive Summary to the VA	--	01-12-88	--	11-07-88

Although the Advance Data Report was submitted to the VA approximately 14 months later than originally specified, and other delays have also been incurred, it is currently envisioned that a draft final report will be submitted to the VA on October 6, 1988, and revised for final submission by November 7, 1988, 9.75 months later than the date originally proposed (and 6.75 months after the dated implied in the RFP).

B. Study Costs

When the contract to conduct the NVVRS was awarded on September 12, 1984, the estimated cost to conduct the research was $3,620,024. Due to the study's comprehensive objectives, however, in addition to a desire by the VA and its Scientific Advisory Board to review, guide, and revise the study design as the project evolved, substantial revisions and enhancements to the study were recommended almost immediately upon contract award and continued throughout the study. As a result, the NVVRS that was conducted was very much different from the study described in the original proposal.

The first such recommended changes were increases in interview length and a comprehensive redesign of the proposed validation study to increase the scientific rigor of that component. Additions to the primary research staff were also recommended and approved, and, most recently, a clinical interview follow-up component for Vietnam era veterans was implemented. Though each of these changes served to increase the scientific rigor and quality of the NVVRS, the resulting study as implemented was quite different than that envisioned in RTI's original proposal. In addition, due to the study's virtually unprecedented complexity and the "groundbreaking" nature of several of its components, it was substantially more time-consuming, difficult, and expensive to carry out than had been envisioned.

Reflecting both of these major influences, the authorized level of funding for this study was increased several times after contract award, most recently to $8,624,860. As of the end of May, 1988, $8,458,153 had been spent. At the most recent review of the budget with VA staff on March 10, 1988, the projected cost to completion for the NVVRS was $9,349,045, with estimated final expenditures attributable to the following basic components:

Component	Cost
1. Instrument Development	$ 237,306
2. Validation Study--Design and Analysis	431,384
3. Abstraction of Military Records	376,927
4. Sample Design, Selection, and Weighting	514,589
5. Tracing	127,342
6. Materials Preparation and Interviewer Training	692,374
7. Interviewing, Editing, and Coding	3,576,797
8. Data Processing	842,937
9. Clinical Interviewing	387,955
10. Analysis and Report Preparation	904,139
11. Subcontracts for Co-Principal Investigators	574,079
12. Management and Contractual Reporting	683,216
Total	$9,349,045

III. ASSESSMENT OF PTSD IN THE NVVRS

Reflecting the emphasis on PTSD in the Congressional mandate, the central concern of the research team in designing the Readjustment Study was the creation of a research design that would maximize the accuracy of the study's estimate of the prevalence of PTSD among Vietnam theater veterans. This concern was expressed through two important features of the NVVRS design. First, at the time that the NVVRS was being planned, the American Psychiatric Association (APA) was in the process of revising its Diagnostic and Statistical Manual (DSM-III), the document that provides the "official" definition of psychiatric disorders in the United States. To assure that the NVVRS assessment of PTSD was consistent with the official definition of PTSD that would be in place by the time NVVRS findings became available, the research team coordinated its efforts with the group working on revising the psychiatric taxonomy--APA's Workgroup to Revise DSM-III. RTI co-sponsored the meeting of the Ad Hoc Panel on the Definition and Measurement of PTSD, whose recommendations for revising the diagnostic criteria for PTSD were incorporated into the revised PTSD definition. As a result of this coordination, the NVVRS clinical estimates of PTSD prevalence are estimates of the prevalence of the disorder as defined in the current official taxonomy (and therefore in use by the VA system).

Second, the bedrock of the accuracy of any diagnostic procedure is it's validity--i.e., the extent to which the procedure classifies individuals in whom the disorder is truly present as cases, and those in whom the disorder is truly absent as noncases. To achieve the objective of diagnostic accuracy, RTI proposed a double validation design that involved conduct of a preliminary validation study prior to launching the national survey (i.e., the NSVG), followed by a second validation study to run concurrent with the national survey. The nature and purposes of these validation components, and the methods for integrating validation study findings with those of the national survey to formulate population prevalence estimates, are described in the following sections.

A. Preliminary Validation Study

One of the fundamental principles on which RTI's original proposal to conduct the NVVRS was founded was that the national survey component of the study should not go to the field until there was sufficient evidence that cases of PTSD could be validly identified on the basis of survey interview information. This was seen as necessary because although several existing survey instruments purporting to identify PTSD had been used in prior research, there was *no published information* concerning the validity of *any* of those instruments.

Therefore, the NVVRS design called for a preliminary study to examine the ability of several candidate survey measures to discriminate "true" cases of PTSD from "true" noncases. The Scientific Advisory Committee overseeing the conduct of the NVVRS on behalf of the VA concurred with the need for this preliminary study, and recommended a more rigorous design than that originally proposed. The validation study as it was conducted involved administering a package of candidate PTSD instruments to a group of subjects whose diagnostic status was known. The diagnostic status of subjects, who were mostly veterans undergoing psychiatric treatment, was "known" because their chart diagnosis *and* the diagnosis made by an expert clinician *agreed* on the presence or absence of PTSD. The expert clinician's diagnosis was made on the basis of an independent diagnostic interview conducted blind to the chart diagnosis

Results of the study indicated that several instruments in the package could classify people as cases or noncases of PTSD with acceptable accuracy. These findings served as the basis for decisions about the package of instruments to be included in the NSVG (details of the design and findings of the preliminary validation study are provided in Appendix A).

B. Clinical Subsample

The preliminary validation study provided information suggesting that it was prudent to proceed with the national survey component of the NVVRS. However, it did not (and it was not intended that it would) provide *complete* information about every aspect of the validity of the survey-based PTSD measures. This is true in part because the validation study's subjects were (of necessity) people who had sought treatment for their mental health problems, and there is evidence in the research literature that persons who seek mental health treatment are different in many ways from people who meet the diagnostic criteria for a psychiatric disorder but who do not seek treatment for it. Since the national survey component of the NVVRS involved a community sample, rather than a treatment seeking sample, it is to be expected that the relationship between the diagnostic measures and "true" diagnosis (i.e., the validity of those measures) would be somewhat attenuated from the estimate made on the basis of a treatment seeking population.

For this reason the NVVRS design contained a clinical subsample component. The primary purpose of the clinical subsample component was to provide additional information about the correspondence between PTSD measures included in the survey interview and "true" PTSD. The clinical subsample was designed as a multimethod validity study, in which multiple PTSD measures, including a semistructured interview conducted by an experienced mental health professional, could be brought to bear on the diagnostic decision. Thus a "triangulation" method for case determination was planned, in which information collected through a variety of methods and from a variety of sources would be taken into account in the diagnostic decision process.

Each clinical subsample respondent underwent a semistructured clinical interview that resulted in a diagnostic decision about PTSD. In addition, the clinician who conducted the interview completed several clinical scales describing his/her clinical impression of the respondent, and the respondent completed several self-report PTSD scales. Also, the spouse/significant other (if there was one) of each clinical subsample respondent was also interviewed. As a result, the research team had at its disposal 5 self-report scales directly related to PTSD (plus a number of other psychiatric symptom scales that are related to PTSD but less directly so), and 4 clinical judgment scales, for clinical subsample respondents. This is the information base on which PTSD case determinations were made.

C. PTSD Diagnostic Procedures

Two methods have been selected to make diagnostic decisions about PTSD in the NVVRS. The first is the clinical DSM-III-R diagnosis, and is the diagnosis made by an experienced mental health professional on the basis of a semistructured diagnostic interview.

Although the research team has great confidence that a PTSD diagnosis made by a trained and experienced mental health professional based on a thorough clinical interview is the best single indicator of the presence or absence of PTSD, we also recognize that no diagnostic procedure is completely error free. Therefore, we sought a way of combining information from the full range of available indicators to form a "composite" PTSD diagnosis. The basic idea of the composite diagnosis is to examine the information available from multiple PTSD indicators, including but not limited to the clinical interviewer's diagnosis, and in those cases where there is some discrepancy among the indicators to use the full array of additional PTSD information to make a diagnostic decision.

Simply stated, composite diagnoses were made on the basis of a detailed review of the PTSD information for each individual clinical subsample subject. Review began by examining the study's three main indicators--the Mississippi Combat-Related PTSD (M-PTSD) scale, the clinical interview (SCID) PTSD diagnosis, and the PTSD scale of the Minnesota Multiphasic Personality Inventory (MMPI). When these three indicators were in agreement, the diagnosis was considered "settled" (decided). In the event of a discrepancy in PTSD diagnosis among the three indicators, information from the study's other PTSD indicators was used to resolve the discrepancy. Information from these other indicators was combined statistically to create two additional main indicators for use in resolving discrepancies [Details of the logic underlying the composite diagnosis procedure and of its relationship to other potential methods of case determination are provided in Appendix B]. Application of this procedure resulted in a composite PTSD diagnosis for every subject in the clinical subsample. At least three primary indicators concurred in the composite diagnosis for every subject[1]. In fact, for 87 percent of clinical subsample respondents four out of five primary indicators agreed on the diagnosis (including 59 percent for whom all five agreed), and for the remaining 13 percent three out of five agreed.

1--For two subjects (less than one half of one percent of the total) only two indicators were available. These were settled by adjudication.

IV. NVVRS PTSD PREVALENCE ESTIMATES

A. Formulation of Prevalence Estimates

The design of the NVVRS incorporated multiple methods for making PTSD prevalence estimates. Detailed results from several alternative methods, and the convergence among the findings, are described in Appendix C. Based on an evaluation of the findings, population prevalence estimates for the projected clinical DSM-III-R diagnosis and the projected composite diagnosis will be presented. These are estimates of the current prevalence of PTSD--i.e., estimates of the number of veterans who have the disorder today. NVVRS estimates of the lifetime prevalence of PTSD--i.e., estimates of the number of veterans who ever had PTSD--will be included in a subsequent report.

B. National Estimates of Current PTSD Prevalence

Exhibit IV-1 shows the estimated current PTSD prevalence rates and corresponding estimated numbers of current PTSD cases for selected Vietnam Theater veteran subgroups from the two estimation methods. It is estimated that 15 percent (±2.6 percent) of all male theater veterans are current cases of PTSD. This represents about 470,000 of the estimated 3.14 million men who served in the Vietnam theater. Among females, the prevalence is estimated to be 9 percent (±2.8 percent) of the estimated 7,166 women who served, or about 650 current cases.

Examination of the findings for racial/ethnic subgroups of male Vietnam theater veterans indicates that the prevalence for white/others is about 14 percent (±3.0 percent), while for blacks the prevalence is 19 percent (±4.5 percent) and for Hispanics as high as 27 percent (±7.0 percent). These observed differences in racial/ethnic subgroup prevalence rates will be examined in detail in a subsequent report to determine the extent to which they may be explained by group differences in other characteristics, such as exposure to war zone stress or other trauma, socioeconomic status, etc.

Exhibit IV-1

NVVRS Estimates of Current Prevalence and Number of Current PTSD Cases Among Vietnam Theater Veteran Subgroups

Theater Veteran Subgroup	Projected Clinical DSM-III-R PTSD Prevalence Estimate	Estimated Number of Current PTSD Cases	Projected Composite PTSD Prevalence Estimate	Estimated Number of Current PTSD Cases
Males	14.7 (±2.6)	453,000	15.3 (±2.6)	481,000
Black	19.4 (±4.5)	68,000	19.3 (±4.4)	68,000
Hispanic	23.2 (±6.5)	39,000	30.9 (±7.5)	52,000
White/other	13.6 (±3.0)	356,000	13.8 (±3.0)	361,000
High war zone stress exposure	30.8 (±6.3)	245,000	38.7 (±6.8)	308,000
Low/mod. war zone stress exposure	9.3 (±2.6)	218,000	7.5 (±2.4)	173,000
Females	8.3 (±2.7)	595	10.0 (±2.9)	716
High war zone stress exposure	13.8 (±5.4)	395	20.4 (±6.2)	582
Low/mod. war zone stress exposure	4.7 (±2.6)	200	3.1 (±1.6)	134
CDC/VES subpopulation	15.2 (±4.2)		15.5 (±4.1)	

Note: Numbers in parentheses below each estimate represents the 95 percent confidence interval for the estimate.

The exhibit also shows rates of PTSD by level of war zone stressor exposure. The NVVRS measure of war zone stressor exposure was developed independently for males and females using the same methodology, and is a summary measure representing exposure to both direct combat (e.g., direct engagement of the enemy, exposure to enemy fire) and other war zone stressors (e.g., exposure to death and dying, exposure to environmental hazards). Details of the derivation of this measure and evidence for its validity are provided in Appendix D.

The NVVRS findings show that for both male and female Vietnam veterans, those exposed to higher levels of war zone stress have higher rates of PTSD today. The PTSD prevalence rate for both males and females with high exposure to war zone stress is three to five times higher than that for their counterparts with moderate or low exposure.

Finally, the NVVRS estimate of the current prevalence of PTSD in the subset of male theater veterans that was studied by the Centers for Disease Control (CDC) in the Vietnam Experience Study (VES) is just over 15 percent (±4.1 percent). A detailed discussion of this subgroup and the differences between the NVVRS and VES estimates is provided in Chapter V.

C. Case Examples

To illustrate how the prevalence rate translates into individual human terms, several case examples were drawn from the NSVG theater veteran sample. These cases were ones for which all five of the primary indicators of PTSD were positive; there is no disagreement that these are cases. The selection of the cases was based on two factors: (a) each was judged by the research team clinicians to embody the hallmark features of PTSD in theater veterans, as well as (b) being sufficiently typical that even with changes made for the purposes of disguising individual identities, the essential attributes of the disorder and their impact on work and interpersonal functioning was recognizably retained. Regarding the three individuals on whom the case descriptions were based, the core of each was a real veteran who participated in the survey and clinical interviews. A number of specific details and identifying data were changed (including the initials) so that the descriptions as presented preserve the confidentiality and anonymity of the respondents while retaining the richness and vividness of his or her individual human experience.

1. Example Case 1

J.S., an Hispanic male veteran in his late thirties, has been married for almost twenty years, has three children, and works as a semi-skilled laborer. He lives in a large metropolitan area in the northeast. He is the eldest of four children, and grew up in a poor but stable and supportive family environment. He was drafted into the US Army in 1966 and served one tour of duty in Vietnam, ending in 1968.

His primary duty was reconnaissance in an infantry unit. He experienced high and sustained warzone stressor exposure; he walked point, was frequently under fire, witnessed the death and injury of close buddies, witnessed the mutilation of the bodies of American troops, and was wounded in combat. He received several decorations including the purple heart.

J.S. reports that his experience in Vietnam matured him, but that he had difficulty coping and began to drink heavily for the first time during his tour. On his return to civilian life his problems with alcohol intensified; he was treated medically for alcohol-related pancreatic disease several years after his return. Alcohol abuse remains a serious problem to the present time.

With respect to the psychological impact of the war, he reported "I developed a nasty temper, became very nervous, and have bad dreams that take me back into the war, like it's happening all over--then I can't get back to sleep". When reminded of the war he becomes upset and vividly imagines the sights and smells of the battle field, including the discovery of bodies that had been left for several days in the jungle heat. He describes himself as frightened by his urges, easily startled, frequently on guard for no reason, emotionally withdrawn, and using alcohol to help forget about his wartime memories. His wife concurs, reporting that he has frequent nightmares, becomes enraged over minor irritations, avoids reminders of the war, and is reluctant to be emotionally close. He says he is fortunate that his wife continues to be supportive, despite his volatility and withdrawal.

He has managed to maintain steady employment and finds satisfaction in his relationship with his children. At present he is most troubled by nightmares, intrusive reliving of painful war memories, alcohol abuse, flashes of temper, difficulty opening up to his wife, and bad nerves as he is frequently on guard, easily startled, has difficulty concentrating, and sleeps poorly.

He has never been treated for emotional problems. He has intermittently received treatment for alcohol abuse, but his drinking problems have not been addressed in the context of his overall post-war psychological adjustment problems.

2. Example Case 2

T.L. is a 38 year old black male living in a primarily blue-collar, working-class suburb of a major city. He has worked for a municipal airport for nearly 15 years, and has been married to his second wife for more than 10 years. T. L.'s parents separated when he was 12 years old, and he and three siblings were raised by his mother in an inner city neighborhood, which he described as "rather poor." He indicated that his relationship with his mother was "good", and that there was no known history of mental illness in his family of origin. Soon after graduating from high school in 1967 he enlisted into the United States Marine Corps.

From early 1968 to early 1969, T.L. served with the US Marine Corps in the Republic of Vietnam, primarily in the vicinity of the DMZ. He reported heavy combat exposure ("daily encounters with booby traps, a lot of firefights"), as well as the experience of multiple combat trauma. At one point in the NVVRS interview, T.L. described his experience in Vietnam in the following way. "It seemed like every time I turned around someone was getting shot, or had a limb blown off, or their guts hanging out. There was nothing that you could do for them." He described one of many specific traumatic incidents in these words: "One time on a mission, a land mine exploded. Three guys were killed ... blown up ... guys on the ground, screaming." T.L.'s voice faded to a barely audible whisper as he described this event to the NVVRS interviewer.

T.L. reported that severe and persistent problems in his daily functioning began within a few months of his return from Vietnam to the United States. From 1970 to the present, he has been plagued relentlessly by symptoms of post-traumatic stress disorder, the impact of which he has attempted to mollify through chronic substance abuse. He painfully acknowledged the continuing presence of distressing, intrusive memories of death and dying in the combat zone ("Sometimes my thoughts take me right back to what happened to guys there. I wish I could have helped them."). In a voice choked with emotion, he said that he currently attempts to avoid thoughts and reminders of Vietnam, but with little success. "I try (to avoid), but it's hard. In my job I deal with the public and it seems like someone or something is always bringing it up." He also clearly described several discrete episodes during which specific, intrusive, traumatic memories of Vietnam overwhelmed his capacity to cope, precipitating what he described as "nervous breakdowns". These episodes were principally characterized by gut-wrenching pangs of guilt, shame, and despair related to the traumatic memories, persistent agitation and sleep disturbance, and desperate attempts to escape and avoid through social withdrawal and alcohol binges. During these periods of debilitating PTSD symptomatology, T.L. consulted his family physician, asking for pills for his unspecified "nerves." At the time of the NVVRS interviews, T.L. was found to meet diagnostic criteria for severe combat-related PTSD, yet he had not been under any physician's care for almost two years. Moreover, he had never sought help for PTSD and associated symptoms of distress from any mental health professional or from the Veterans Administration.

3. Example Case 3

This currently unmarried Vietnam veteran living in a large metropolitan area was in her late forties at the time of her participation in the study. She was in the service for more than 15 years and received numerous decorations and commendations. She was one of six children raised by both parents in a happy home. She was trained as a nurse and enlisted in the Air Force because it "sounded interesting."

B.R. volunteered for duty in Vietnam and served one tour in 1966-67 as a nurse, primarily caring for wounded soldiers in the area of her nursing expertise. Periodically, however, she was assigned to care for patients with injuries or trauma that required expertise outside of her primary area of skills. These episodes were very stressful; sometimes they involved supportive care of obviously terminal patients. She was exposed to mortars infrequently, but when shelling occurred it was always totally unexpected and B.R. found these frightening.

She experienced the death of several people with whom she had developed deep attachments--both professionally and personally. Her account of her reactions to these mounting losses was a gnawing lack of time and privacy to mourn because of the exhausting and grinding nursing care she was asked to and willing agreed to provide. She described her Vietnam service as both the most exciting part of her Air Force career as well as the most distressing, damaging, and traumatic. B.R. recounted that she felt it was especially hard for her to deal with the experiences of what she felt were pointless deaths and injuries and the denial of impending death by those who were terminally injured.

Her return from Vietnam was distressing--she was ostracized, shouted at, and felt ashamed, though she continued her military service. She received commendations for her post-Vietnam service, and reported few psychological signs or symptoms of upset during the span of 10-15 years prior to her return to civilian life. She did report, however, a persistent sense of distance and social withdrawal, though she did not seem to connect these to her service in Vietnam during that period.

It was only upon her return to civilian life and her selection of a job that exposed her daily to people dealing with their own traumas, past and present, that her functioning began to deteriorate. B.R. became increasingly withdrawn, irritable, and depressed. She began to have intrusive thoughts about her war experiences, and began awakening in early morning from dreams of her time in country. She could not concentrate, was jumpy and easily startled, felt numb inside, and was prone to angry outbursts.

She felt that no one could understand how she felt and that she was not able to feel close to anyone. Though she desired closer contact with both men and women, B.R. was unable to reach out or trust enough to get closer. Her episode of Post-traumatic Stress Disorder was a clear case of delayed-onset PTSD; most symptoms began well over a decade after the trauma.

Because both her work and interpersonal functioning were impeded, she was encouraged to seek treatment which she reluctantly did. Though finding the treatment program she selected in the VA system helpful, she is aware that her recovery will be a long process because she now sees that she has buried and avoided a number of powerfully painful feelings for a long time and that it will take time to deal with each one in turn.

V. COMPARISON OF THE NVVRS WITH THE CDC VIETNAM EXPERIENCE STUDY

A. Background

Prior to the initiation of the NVVRS, no previous research had been completed that would support the derivation of population-based, diagnostic estimates of the prevalence of PTSD among Vietnam veterans. In part, this was due to the absence of any official diagnostic criteria of PTSD prior to the publication of the third edition of the Diagnostic and Statistical Manual (DSM-III) by the American Psychiatric Association in 1980. As a result, studies published prior to 1980 were forced to employ more general conceptions of the symptoms of this disorder.

Immediately after the appearance of the criteria, the only instrumentation available to researchers for measuring the criteria were understandably lacking in polish and precision. Thus, even though some early estimates of the prevalence of problems of stress, adjustment, and mental health among Vietnam veterans were available, based as they were on expert opinion and clinical samples (e.g. Mantell & Pilisuk, 1975; Schindler, 1980; Walker, 1981; Walker & Cavenar, 1982; Wilson, 1980), the relationship of these projections to the prevalence of post-traumatic stress disorder defined by the nomenclature could still not be assessed. Similarly, estimates developed by three major surveys conducted during this period that involved broader and more representative samples of Vietnam veterans (Card, 1983; Egendorf et al., 1981; Fischer et al., 1980) were similarly hampered by an inability to link measures of "mental or emotional problems" or "stress" to the diagnostic criteria of PTSD.

One of the first advances in this domain was the development of a questionnaire module to assess PTSD for the Diagnostic Interview Schedule (DIS; Robins et al., 1981), a highly structured survey interview instrument designed explicitly for use by lay interviewers (i.e., nonclinicians). The DIS was originally developed by Washington University in St. Louis under the auspices of the National Institute of Mental Health for use in a landmark study of the mental health of community and institutionalized respondents in the United States--the five site Epidemiologic Catchment

Area (ECA) project. The DIS comprises multiple modules, each designed to detect the presence of a different psychiatric disorder according to one of several diagnostic systems, including DSM-III. The PTSD module was developed only after the ECA studies were underway and was used only during the second wave of interviewing (one year after the first). Slightly different versions of this module were used by the St. Louis and the North Carolina ECA sites; the Los Angeles ECA site employed a version with considerably more differences. Moreover, because it was added at a later date, the PTSD module was not included in the validation studies of the other DIS modules.

Although no estimates of the prevalence of PTSD have yet been published based on data from either the North Carolina or Los Angeles ECA sites, Helzer and his colleagues (1988) recently reported such an estimate from the St. Louis ECA data based on the 64 Vietnam veterans in their sample. They indicated a lifetime (ever had) prevalence rate of 6.25 percent for combat-related PTSD, in comparison with a 1 percent lifetime rate for any PTSD for the total population. Because of the small size and geographically limited nature of their sample, the estimates cannot be taken seriously as either general or reliable estimates of the prevalence of PTSD in the population of for Vietnam veterans.

The recently published study by the Centers for Disease Control (CDC, 1988) is not subject to the same sample-based restrictions. The CDC Vietnam Experience Study (VES) is by far the largest, most representative, and sophisticated research project to date to report on the psychological status of Vietnam veterans. A random subsample of 2,490 Vietnam veterans was selected from a larger sample of 7,924 who had entered the U.S. Army between 1965 and 1971. Using a slightly modified version of of the PTSD module of Version IIIA of the DIS, the CDC research team estimated that approximately 15 percent of these veterans had experienced combat-related PTSD at some time during or after their military service, but that the prevalence of the disorder during the one month immediately prior to the assessment was 2.2 percent. This 2.2 estimate based on the VES stands in stark contrast to the estimate of 15 percent for current prevalence of PTSD derived from the NVVRS and reported in Chapter IV.

Because both of these estimates are based on large samples of Vietnam veterans (in fact a quite similar sampling scheme was utilized by both) and conducted according to high scientific standards, a discrepancy in the estimates of the magnitude found is cause for considerable concern. Such a difference requires thoughtful and careful consideration and it is of great importance to achieve an understanding of the reasons underlying this difference. In the remainder of this chapter we describe in some detail several activities undertaken by the NVVRS research team in an effort to account for this difference and to understand how it may have occurred.

B. Differences in Samples

The CDC Vietnam Experience Study sample was selected from military personnel records from a random sample of male U.S. Army veterans who served during the Vietnam era. To increase comparability between those who served in Vietnam and those who served elsewhere, the sample was restricted to those who (1) entered military service for the first time between January 1965 and December 1971; (2) served only one term of enlistment; (3) had at least 16 weeks of active service; (4) earned a military occupational specialty other than "trainee" or "duty soldier;" and (5) had a pay grade no higher than E-5 (sergeant) when discharged from active duty.

As noted in Chapter I, the NVVRS sample was also drawn from military records, but was drawn to represent all veterans serving on active duty during the Vietnam era, excluding only those still on active duty. Since the methodology used to draw these two samples was quite similar and the population represented by the VES sample is a logical subset of the NVVRS target population, it was possible to isolate this subsample in the NVVRS data set. We did this by using the CDC sample selection criteria described above to identify "VES eligibles." To ensure the accuracy of this procedure in representing the VES target population, these criteria were assessed independently on both the military records and interview data for each NVVRS respondent. Any discrepancies that were identified between these two sources of data were examined and resolved by examination of all available data.

This procedure resulted in the identification of 484 male Vietnam theater veterans meeting the CDC VES criteria, representing an estimated 35.9 percent (weighted) of the total male Vietnam theater veteran population interviewed in the NVVRS. Given the nature and relative proportion of this subsample, there exists a strong potential for substantial differences in demographic and/or psychosocial characteristics between the VES-matched subsample and the total NVVRS sample of male theater veterans. However, other than some obvious differences on factors related directly to the selection criteria (e.g., dates of entry to active duty, dates of separation, months of active duty, pay grade at discharge) surprisingly few differences were found between this subsample and the total NVVRS sample of male theater veterans. The NVVRS matched-VES subsample is much younger and much more likely to have been drafted than the total NVVRS male theater veteran sample, as well as somewhat more likely to live in the North Central States (less in the West) and is less likely to have entered the military from a medium-sized city. No significant differences were evident, however, for such characteristics as race, ethnicity, education, AFQT scores, or receipt of an Article 15. Consistent with these "demographic" characteristics, the proportion of men in the matched-VES subsample who scored above the designated diagnostic cutoff on the NVVRS M-PTSD measure was 23 percent compared to 20.9 percent for the total NVVRS male theater veteran sample.

When the NVVRS criteria and methods for deriving a diagnosis of PTSD were applied to the matched-VES subsample, the estimated current prevalence rate is 15.2 percent for the projected clinical DSM-III-R diagnosis and 15.6 for the projected composite diagnosis. These rates are remarkably similar to the estimates in Chapter IV for the full population of male Vietnam theater veterans (14.7 and 15.3, respectively). Thus, the difference observed in current prevalence estimates between the CDC Vietnam Experience Study and the NVVRS does not appear to reflect differences in the populations sampled even though the two populations are quite different on some military characteristics.

C. Differences in Instrumentation and Methodology

Given the absence of observed differences between the CDC and NVVRS samples, differences in the measures and methods used to generate the diagnosis of PTSD appear to be the most likely alternative explanation of the discrepancy in the rates of current prevalence of PTSD between the two studies.

As described in Chapter III, the NVVRS employed a multiple methods approach to the assessment of symptoms of PTSD. The derivation of diagnoses was based on DSM-III-R criteria (the criteria currently in use by the Veterans Administration and the standard in use across the country by mental health clinicians to diagnose this disorder). By contrast, the CDC study employed a slightly revised version of the DIS Version III-A PTSD Module and established diagnoses of PTSD based on the no longer current criteria elaborated in DSM-III.

The NVVRS approach is clearly both more comprehensive as well as more complex than that used by the CDC. It is based on the convergence of a set of survey and clinical measures of established validity with the added refinement of clinical review and adjudication of the most diagnostically ambiguous cases (i.e., cases where the multiple measures diverge). The CDC methodology is based on the PTSD module of the DIS whose capacity to distinguish true cases of PTSD from noncases has still not been established.

It is important to note, however, that because the DIS has been widely regarded as the "state of the art" for the assessment of psychiatric disorder and derivation of estimates of incidence and prevalence of diagnoses from survey data, the NVVRS study team felt it vital to include a version of the DIS in the survey. As a consequence, the DIS, including a modified PTSD module, is a significant component of the NVVRS instrumentation.

The choice of the particular DIS PTSD module was not straightforward, however, for several reasons. There were several versions in existence at the time the NVVRS instrumentation was being selected, although none had been validated. The diagnostic criteria for PTSD were in transition from DSM-III to DSM-III-R. The research team grappled with this choice by consulting with a nationally-recognized panel of expert clinicians. Together, they developed detailed guidelines for a new module for the diagnostic assessment of PTSD, with a style and format consistent with other DIS modules. This new "DIS-type" measure would be able to assess symptoms of PTSD using either DSM-III and DSM-III-R criteria, as well as addressing concerns raised by these experts about versions of the PTSD module of the DIS in use at that time (including the St. Louis and North Carolina versions). The resulting "DIS-type" PTSD measure was then included as one of several measures in the Validation Study described in Chapter III and Appendix A. As shown in Appendix A (Exhibit A-3), in the "treatment-seeking" sample (i.e., Vet Center and VA Medical Center patients) used for the Validation Study, this modified and revised PTSD module performed sufficiently well in distinguishing cases from noncases to be carried forward to the main NSVG study. The module attained a sensitivity of 87.2, a specificity of 72.6, and a Kappa = .639 with the certified clinical diagnosis.

1. PTSD Prevalence Estimates Based on the NVVRS DIS-Based Type

Using the modified DIS-type instrument and the associated scoring algorithms developed and evaluated in the Validation Study, several estimates of the prevalence of PTSD were developed based on the full NSVG sample. First, because of the transition of the official nomenclature from DSM-III to DSM-III-R during the study period, estimates were computed using both sets of criteria. Second, because the majority of published studies from the ECA project on the prevalence of psychiatric disorders other than PTSD employed a six month cut-off for current prevalence, and because expert clinicians involved in the NVVRS felt that using a six month, as opposed to one month, time frame more effectively captured the clinical phenomenology of the waxing and waning of intrusive and avoidant symptoms in relation to current stressors, estimates of current prevalence of PTSD were computed using a six month cut-off. For purposes of comparison with other studies, including the St. Louis ECA and CDC VES, however, we also calculated separate one month estimates using both the DSM-III and the DSM-III-R criteria. Finally, we distinguished between PTSD related to any trauma and solely combat-related PTSD.

These estimates are presented in parts I and II of Exhibit V-I, along with those from the CDC Vietnam Experience Study. From this table it is evident that the NVVRS estimates using the DIS-type instrument and the DSM-III criteria are very similar to those reported by the CDC. The lifetime prevalence rate is 14.9 percent, and the current one month prevalence rate is 3.9 percent. Though the current prevalence rate is almost twice the rate reported in the CDC VES, it is far closer to 2.2 than it is to the 15.3 percent NVVRS current prevalence rate using the projected composite diagnosis.

An increase in the interval defining the disorder from one to six months increases this estimate by 50 percent, from 4 to 6 percent. Both the application of the DSM-III criteria as well as the restriction to combat-related PTSD only results in a decrease of the current estimate to as low as 3.3 percent, though the general pattern remains: using the DIS-type measure developed for the NVVRS results in estimates of current PTSD prevalence substantially consistent with those reported by the CDC and closer to those of the CDC than to those that obtained using the full instrumentation and diagnostic methodology of the NVVRS.

2. Estimates of PTSD Prevalence Based on Matching NVVRS DIS-Type Instrumentation and Procedures to those used by the CDC

In addition to the difference between the CDC VES and NVVRS samples described above, the two studies differed in their instrumentation in important ways. The DIS-type instrument used in the NVVRS as well as the scoring algorithm are materially different from those of the CDC. Given this consideration, we felt it necessary to further explore similarities and differences in the estimates of PTSD prevalence derived from these studies. As a result, the research team used the NVVRS study data to conduct a set of analyses designed to simulate as closely as possible the instrumentation and scoring procedures used by the CDC VES. The estimates derived from these analyses included some that were restricted to the NVVRS matched-VES subsample described previously.

The NVVRS DIS-type PTSD measure employed multiple items for the various DSM-III and DSM-III-R subcriteria, whereas the CDC measure had no more than one item for each diagnostic subcriterion. Consequently, it was possible to construct a "CDC-matched" DIS-based measure. To do so, the best matching single NVVRS item was selected for each CDC criterion item. (See Exhibit E-1 in Appendix E for a comparison of items from the CDC DIS with those from the NVVRS DIS-type module). Substantively, the match was very close, with the only really poor "fit" occurring on subcriterion D6--intensification of symptoms in situations reminiscent of the traumatic event. The CDC item asked directly whether the respondent had experienced this phenomenon. The NVVRS DIS-type measure approached measurement of this criterion differently. Respondents were asked if anxiety symptoms that they had reported earlier in the interview had ever occurred because they had been reminded of a traumatic event.

Other criteria had less than identical matches. The NVVRS item "disturbing memories" was used to match the CDC item "remember horrible things." "Found it difficult to feel close to other people" in the NVVRS survey was used as a match for the CDC item "less ability to care about others". An NVVRS item inquired about "difficulty falling asleep" while the CDC inquired about "trouble sleeping (falling asleep, staying asleep, not able to sleep)." Finally the CDC item "ashamed of being alive" was assessed in the NVVRS by asking if respondents "felt guilt."

In addition to matching items, the scoring algorithm and decision rules for making the diagnosis of PTSD used by the CDC was simulated very closely for the NVVRS data. It was possible to replicate this procedure reasonably well. Both the CDC and NVVRS simulation of these procedures (1) used DSM-III criteria; (2) did not use any DSM-III diagnostic exclusion criteria; (3) did not require the respondent to meet any test of severity for either individual items or the total disorder; (4) included only a combat-related traumatic event; and (5) used the one month cut-off for establishing current prevalence.

There were two major differences between the CDC procedures and the NVVRS simulation. First, the NVVRS DIS-type survey instrument required linkage of symptoms to the traumatic event only for the intrusive symptom criteria (the "B" criteria of the DSM-III), whereas the CDC procedure required linkage for all criterion items. Second, the CDC procedure asked respondents only if they had ever had any particular symptom. The NVVRS

DIS-type instrument not only asked if respondents had ever had a criterion symptom but also whether it was present for a week or more. In the NVVRS simulation, these two differences would tend to have opposite effects (i.e., one would tend to produce higher rates the other lower rates). Though the simulation was not perfect, it was reasonably similar to the CDC procedure.

The results of the simulation, including a restriction to the matched-VES subsample, are presented in the last panel of Exhibit V-I (Part III). Application of the simulation procedures to the full NVVRS sample of male Vietnam theater veterans resulted in a one-month current prevalence estimate for PTSD of 2.1 percent, virtually identical to the CDC's own estimate of 2.2 percent (Part IA of the same exhibit). In contrast, the lifetime prevalence estimate of 7.1 percent is considerably lower (less than half of) than the CDC estimate. When the simulation procedure was applied to the NVVRS matched-VES subsample only, the subsample directly comparable to the VES sample, the lifetime prevalence estimate increased only slightly--to 7.8 percent--while the one-month current prevalence estimate decreased slightly--to 1.4 percent.

What these results demonstrate is that when a CDC-matched instrument and scoring procedure are utilized with NVVRS data the estimates of current prevalence are statistically indistinguishable from those published by the CDC Vietnam Experience Study, though the simulated lifetime prevalence estimates are substantially lower than the CDC's. Moreover, consistent with our discussion of the similarities of the samples, estimates derived from the ostensibly quite atypical CDC population do not differ much from those for the total population of men serving in the Vietnam theater of operations.

3. Validity of the NVVRS Estimates Based on DIS-Type Instrumentation

The findings of the analyses using the simulation procedures indicate that the estimates of current prevalence of PTSD from the NVVRS using a DIS-type PTSD module result in figures substantially closer to those reported by the CDC than to those derived from the other NVVRS measures. In combination with the consistently observed absence of differences between the matched-VES subsample and the full NVVRS sample of male theater veterans, these observations suggest that the dramatic differences in estimates of current prevalence of PTSD from the CDC and the NVVRS are predominantly (if not exclusively) due to differences in instrumentation rather than samples. The differences in the DIS-like measures and algorithms used in the two studies are substantial enough, however, to prevent this from being stated with full certainty.

Given these differences, the single remaining important question is the extent to which these divergent estimates are based on equally valid criteria and methods. The Validation Study conducted prior to the NSVG had shown that the NVVRS DIS-type PTSD module performed relatively well in distinguishing cases of current PTSD from noncases in treatment-seeking veterans. The measure performed sufficiently well to be included in the national survey. Nonetheless, as discussed in Chapter III, the national survey component of the NVVRS predominantly involved the assessment of PTSD in a community sample, rather than a treatment-seeking sample, and the research literature suggests that relationships between diagnostic measures and "true" diagnoses (i.e. the validity of such measures) tend to decline somewhat in moving from treatment-seeking to general (community) populations. Thus, the NVVRS felt it important to field a clinical follow-up subsample component which would allow a further examination of the validity of its measures in the general population of (non-treatment-seeking) veterans.

As described in Chapter III and Appendix B, each of the PTSD measures used in the NVVRS was examined in relation to two standards of "caseness" derived from the clinical subsample (all of whom were interviewed by an expert clinician). In contrast to the relationships observed in the Validation Study, diagnoses generated by the NVVRS DIS-type measure did not do well in distinguishing cases from noncases in our clinical follow-up subsample. In contrast to its sensitivity of 87.2, specificity of 72.6 and Kappa of .639 in the Validation Study, it exhibited a sensitivity of only 21.5, specificity of 97.9 and Kappa of .256. (Comparable concordance estimates with the Composite PTSD diagnosis were 22.7, 99.5, and .285, respectively.) Thus, while this measure was quite successful in correctly identifying noncases, it was able to identify only 22-23 percent of the cases of PTSD as diagnosed either by the expert clinician or by multiple indicators, a level of sensitivity to PTSD caseness far below acceptable levels. In comparison to the other measures presented in Exhibits B-5 and B-6, the sensitivity and Kappa (i.e., measure of agreement between two measures adjusted for chance) for this measure were far worse. For example, the M-PTSD, the other survey-based measure carried forward from the Validation Study, exhibited a sensitivity of 77.3, specificity of 82.8 and Kappa of .528 in relation to the DSM-III-R clinical diagnosis, and 82.4, 86.8, and .644, respectively, in relation to the composite PTSD diagnosis.

Similar measures of concordance were computed for the diagnoses generated by the instrumentation and algorithms used to simulate the CDC methodology using the DIS-type measures in the NVVRS, with even more sobering results. While this simulated measure correctly identified as PTSD-positive 100% of the noncases as noncases (i.e., specificity of 100.0), it correctly identified less than 12 percent of the cases identified by the composite PTSD diagnosis, for a Kappa of only .160. (Estimates using the DSM-III-R clinical diagnosis are virtually identical.) Although the poorer performance of the latter may result in part because the composite measure is calibrated against DSM-III-R rather than DSM-III criteria, the effect of this should be relatively minor. In fact, because the DSM-III-R criteria are somewhat more stringent than those of DSM-III, it might be expected that the CDC-simulated diagnosis would tend to have a somewhat lower specificity and higher sensitivity than the NVVRS DIS-type measure based on DSM-III-R criteria.

D. Conclusions

Our analysis of the various factors that could account for the differences in prevalence rates between the CDC and NVVRS studies suggest that the difference is primarily the result of differences in the measures used to assess PTSD. Diagnoses derived from all of the DIS-type algorithms produce lower prevalence estimates than the current NVVRS estimates of 15 percent. The low sensitivity exhibited by the DIS type diagnoses suggests that the lower estimates derived from these DIS-type measures are a result of a tendency to miss "true" cases of the disorder and thereby underestimate true prevalence. (Although the reasons for this inability to detect PTSD cases are not entirely clear, some thoughts about why this might be the case are presented in Appendix E.) Prevalence estimates developed from the NVVRS DSM-III-R clinical and composite methods on the VES-matched sample are both 15 percent. For the VES-matched sample using the M-PTSD measure, it is 23 percent. These are substantially the same as those obtained on the total NVVRS sample of male theater veterans. This suggests that the study population characteristics and interviewing procedures probably do not account for the overall differences observed in PTSD prevalence. Although the evidence is not complete, in our opinion it is quite compelling, and it appears that the low estimates derived from the CDC Vietnam Experience Study result primarily from their reliance on an instrument that is not sufficiently sensitive to detect true PTSD cases in a community population.

Exhibit V-1

CDC DIS PTSD Prevalence Estimates and Analogous NVVRS DIS-Type Estimates[1]

I. ORIGINAL CDC DATA	
A. Current (one month)	2.2
B. Lifetime	14.7
II. NVVRS DIS DATA	
A. DSM-III Criteria	
1. Current (one month)	3.9
2. Current (six month)	6.0
3. Lifetime	14.9
B. DSM-III-R Criteria	
1. Current (one month)	3.5
2. Current (six month)	4.7
3. Lifetime	12.0
C. Specific Combat Related Only	
1. DSM-III Criteria	
(a) Current (one month)	3.7
(b) Current (six month)	5.4
(c) Lifetime	12.4
2. DSM-III-R Criteria	
(a) Current (one month)	3.3
(b) Current (six month)	4.2
(c) Lifetime	9.6
III. NVVRS DATA CDC SCORING ALGORITHM (DSM-III Criteria and Specific Combat Related Only)	
A. All NVVRS Theater Veterans	
a. Current (one month)	2.1
b. Lifetime	7.1
B. CDC Matched Subsample	
a. Current (one month)	1.4
b. Lifetime	7.8

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[1] The NVVRS DIS-Type estimates are not those used by, and are not equivalent to, the NVVRS prevalence estimates of PTSD provided in Chapter IV.

Appendix A: NVVRS Preliminary Validation Study

I. STUDY DESIGN

The design of the preliminary validation study involved administering a package of candidate instruments to groups of subjects whose diagnostic composition was known. The study was designed as a quasi-experiment in which two factors were manipulated: (1) the presence or absence of the diagnosis of PTSD, and (2) the presence or absence of one or more other psychiatric disorders. A two-way design was selected because of the need to be certain that the survey instrumentation was sensitive and specific enough to be able to detect PTSD both when it occurs by itself (i.e., with no concurrent diagnoses) and when it occurs in the presence of other psychiatric disorders--i.e., the instrument must be capable of differential diagnosis. This design is represented schematically in Exhibit A-1, which defines four distinct diagnostic subgroups: (1) persons who meet the DSM-III-R criteria for PTSD and who meet the criteria for one or more concurrent (Axis I) diagnoses; (2) persons who meet the DSM-III-R criteria for PTSD and who have no other concurrent psychiatric diagnosis; (3) persons who do not meet the DSM-III-R criteria for PTSD but who do have one or more other psychiatric diagnoses; and (4) persons who meet the criteria for no current (Axis I) diagnosis (and never have for PTSD).

An important aspect of the design of any validation study is the procedure by which the criterion is operationalized. In this instance, the criterion is the presence or absence of PTSD, and an elaborate procedure was implemented to "certify" the PTSD diagnosis. Except for the "no diagnosis" group, study subjects were recruited from among the patient populations at participating service facilities at eight sites: (1) Tampa, FL; (2) Boston, MA; (3) Cleveland, OH; (4) Philadelphia, PA; (5) Jackson, MS; (6) Denver, CO; (7) San Francisco, CA; and (8) Portland, OR. A "site" represented a geographical area (e.g., Denver, CO), and service agencies participating at the sites included VA Medical Centers, Veterans Outreach Centers, community mental health centers, and contract

EXHIBIT A-1

NVVRS Preliminary Validation Study Design:

A Quasi-Experiment Involving Two Factors:

		Other Psychiatric Disorder	
		Present	Absent
PTSD	Present		
	Absent		

The four cells of the design are operationally defined as follows:

(1) *PTSD present, other Axis I disorder present* - Person currently meets the DSM-III-R criteria for PTSD *and* for one or more other DSM-III Axis I disorders;

(2) *PTSD present, other Axis I disorder absent* - Person currently meets the DSM-III-R criteria for PTSD but *does not* currently meet the criteria for any other DSM-III Axis I disorder;

(3) *PTSD absent, other Axis I disorder present* - Person *never* met the DSM-III-R criteria for PTSD but does currently meet the criteria for one or more other DSM-III Axis I disorders;

(4) *PTSD absent, other Axis I disorder absent* - (This group was recruited from the community with the assistance of local veteran organizations, *not* from patient populations) - person *never* met the DSM-III-R criteria for PTSD *and does not* currently meet the criteria for any other DSM-III Axis I disorder.

providers (private providers holding contracts with the VA to provide services).

The procedure for recruitment of subjects into the study involved "nomination" by staff clinicians at participating agencies of persons from among their caseloads who fit the definitions of the study groups (subjects for the "no disorder" group were recruited through contacts with local veterans organizations). Prior to acceptance into the study, potential subjects underwent a structured clinical interview with an independent expert clinician who was blind to the chart diagnosis in order to "certify" the diagnosis. The interview used was the Structured Clinical Interview for DSM-III-R (SCID), and participating expert clinicians were trained in its use in a three-day session conducted by Drs. Robert Spitzer and Janet Williams, the developers of the SCID.

Cases in which the independent clinical interview diagnosis agreed with the chart diagnosis were accepted into the study. Cases in which the diagnosis differed were subjected to an elaborate "adjudication" procedure, and were accepted only if diagnostic agreement could be obtained. The adjudication procedure involved review of treatment records by the interviewing clinician, discussions between interviewing and treating clinicians, and review of all case material by a third clinician when necessary. Most disagreements resulted from under-diagnosis on the part of the treating clinician--e.g., cases in which the chart diagnosis was PTSD but the person also met the diagnostic criteria for another disorder (e.g., dysthymic disorder, generalized anxiety disorder). A total of 243 subjects were ultimately certified for participation.

Subjects certified for inclusion then underwent a five hour survey interview conducted by an experienced (nonclinical) survey research interviewer. This interview covered subjects' military experience, history of psychiatric symptoms, history of health and mental health service utilization, and related topics. The interview contained four measures and aimed at identifying PTSD: (1) a fully structured diagnostic PTSD interview (D-PTSD) aimed at assessing the criterion symptoms of PTSD that was developed by the research team in the style of the Diagnostic Interview Schedule (DIS), (2) a checklist of PTSD symptoms, (3) the Mississippi Scale for Combat-Related PTSD (M-PTSD), and (4) the Impact of Event Scale (IES). Additionally, subjects were asked to complete form AX of the Minnesota Multiphasic Personality Inventory (MMPI), which provided the Fairbank-Keane PTSD scale. A total of 225 (93%) of the certified subjects completed the survey interview, and 130 (58%) also completed the MMPI. The response rate for the MMPI was substantially lower than for the interview itself because it was a "leave behind"--i.e., upon completion of the survey interview the interviewer left it with the respondent with instructions to complete and mail it back in its postpaid envelope. It was decided to handle the MMPI in this fashion in order to reduce somewhat the burden on respondents.

II. FINDINGS

Exhibit A-2 presents selected demographic characteristics of the total study sample, and separately for cases and noncases of PTSD. Subjects were virtually all male Vietnam theater veterans, mostly white (about 80%), and mostly in their late thirties to early forties (mean age about 39). The majority were currently married (about 56%) and currently working (about 60%). Most enlisted in the armed forces (75%) and served in either the Army (60%) or Marine Corps (about 25%). About half characterized their Vietnam service as "mostly combat", while more than 40 percent described it as "mostly combat support".

Exhibit A-3 shows the classification results for the five candidate measures included in the study, using the final clinical diagnosis as the criterion. The predictive validity of each candidate PTSD measure was assessed in terms of: (1) the percent of subjects correctly classified as having or not having PTSD; (2) the Kappa statistic, a chance-corrected index of the agreement between two assessments; (3) sensitivity, or the percent of true cases classified as positive by the survey measure; and (4) specificity, or the percent of true noncases classified as negative by the survey measure. As indicated, all of the candidate measures performed reasonably well, with the M-PTSD Scale and the D-PTSD providing the best prediction of the certified clinical diagnosis.

On the basis of findings from this preliminary validation study, certain decisions were made about instrumentation for the National Survey of the Vietnam Generation. First, the M-PTSD and the D-PTSD were both

Exhibit A-2

Selected Characteristics of NVVRS Validation Pretest Sample, by PTSD Diagnosis

Characteristic	Total Sample (N=210)	PTSD Cases (N=137)	Non-PTSD Subjects (N=73)
Sex			
% Male	98.1	100	94.5
Age			
Male	38.5	37.7	39.8
Race			
% White	81.4	81.0	82.2
% Black	16.2	17.5	13.7
Hispanic Origin			
% Hispanic	4.3	4.4	4.1
Marital Status			
% Married	56.2	55.5	57.5
% Divorced	25.7	26.3	24.7
Employment Status			
% Working	60.9	51.9	77.8
Entrance into Military			
% Drafted	25.1	26.3	22.9
Branches Served In			
% Army	59.1	61.2	55.3
% Navy	9.3	8.6	10.5
% Air Force	8.84	3.6	18.4
% Marines	22.8	26.6	15.8
Rank			
Enlisted	91.4	94.2	86.3
Disciplinary Action			
% Ever	43.1	47.8	34.3
% Article 15	35.7	38.7	30.1
% Court Martial	10.5	11.0	9.6
Number of Tours			
% One	82.4	81.0	84.9
% Two	13.8	14.6	12.3
% More than Two	2.9	2.9	2.7
Duty Status			
% Combat	47.1	54.9	32.9
% Combat Support	43.2	42.1	45.2
% Service Support	9.7	3.0	21.9

Exhibit A-3

Relative Diagnostic Accuracy of PTSD Measures

Measure	Percent Correctly Classified	Kappa	Sensitivity	Specificity
M-PTSD Scale	88.9	.753	94.0	79.7
D-PTSD Scale (sum of positive items)	87.5	.714	95.5	72.6
PTSD Checklist	84.9	.672	88.3	78.9
D-PTSD Scale (scored nosologically using DSM-III)	83.5	.639	87.2	72.6
MMPI (Fairbank-Keane Scale)	81.5	.605	90.1	68.8
Impact of Event Scale	81.6	.565	91.7	61.8

Legend:

Percent Correctly Classified is the percent of the entire sample (true cases and true noncases) that are correctly classified by the survey measure.

Kappa is a measure of the extent of agreement between two assessments corrected for the effects of chance. (Kappas above .75 are considered to indicate excellent agreement, those between .40 and .75 fair to good agreement, and those below .40 poor agreement.)

Sensitivity is the percent of "true" cases that are classified as cases by the survey measure.

Specificity is the percent of "true" noncases that are classified as noncases by the survey measure.

included in the survey interview. This provided two assessments of PTSD, and allowed PTSD prevalence to be estimated for theater veteran, era veteran, and civilian counterpart groups (the "standard" M-PTSD contains many items that refer specifically to experiences that occurred when the respondent was in the military, and consequently is not suited for use with a civilian population). Second, it was decided to include the MMPI as part of the Clinical Interview Subsample component of the NVVRS. This component involved semi-structured clinical interviews conducted by experienced mental health professionals with samples of both Vietnam theater and era veterans. The subsample was selected based on responses to the survey interview, and included persons who appeared on the basis of their survey responses to be PTSD cases as well as some who appeared to be noncases.

Appendix B: NVVRS PTSD Diagnostic Procedures

I. INTRODUCTION

The purpose of this appendix is to provide details of the logic and implementation of the procedures for making PTSD diagnostic decisions in the clinical subsample component of the NVVRS. The following sections describe the design of the clinical subsample component, the underlying logic and the results of the clinical DSM-III-R and composite diagnosis procedures, and provide comparisons of these diagnoses with those that would have resulted from some alternative diagnostic decision rules.

II. CLINICAL SUBSAMPLE DESIGN

The NVVRS clinical subsample was designed to be a mechanism for collecting information to improve the accuracy of the study's estimates of PTSD prevalence. The basic idea was to select a subgroup of the NVVRS survey interview sample for whom a more thorough, and therefore in principle more accurate, diagnostic assessment would be conducted. This more thorough assessment included a semistructured, diagnostic interview conducted by a mental health professional experienced in the diagnosis and treatment of PTSD. The findings of this more thorough assessment could then be used to "calibrate" survey-based findings.

Implementation of a follow-up clinical interview in a study in which the initial sample is geographically scattered presents certain logistical problems. In principle the strongest design might have been to select subjects for follow-up interviews without regard to their geographical location. However, doing so would have required sending experienced mental health professionals all over the country to conduct the interviews. This would have greatly expanded the amount of the professional's time that was required to conduct the interview, without improving the quality of the interview. This increase in time (and therefore cost) was seen as undesirable. Alternatively, subjects could have been asked to travel to a specific site where all clinical subsample interviews would be conducted, as CDC did in conducting the physical examinations for the Vietnam Experience Study. Instead, a compromise plan was developed under which the clinical subsample would be drawn from among those survey interview respondents who lived within reasonable commuting distance of 28 specific locations across the country. The locations were selected to maximize the proportion of the Vietnam theater veteran population that would be covered by the subsample, and in each of the locations a mental health professional experienced in the diagnosis and treatment of PTSD was recruited to conduct the interviews. More than forty percent of Vietnam theater veterans met this geographical criterion and were thus eligible for inclusion in the clinical subsample.

A total of 30 mental health professionals conducted NVVRS clinical interviews. The criteria for selection of clinical interviewers were: (1) doctoral-level training in one of the four core mental health professions [24 of those selected were clinical psychologists, 5 were psychiatrists, and 1 a doctoral-level nurse], (2) licensed to practice in their state, (3) at least 5 years of clinical practice experience, (4) experience in the diagnosis and treatment of PTSD, and (5) no current affiliation with a Veterans Administration treatment program. All interviewers were trained in the use of the Structured Clinical Interview for DSM-III-R (SCID) by either the developers of the SCID or the NVVRS clinical co-principal investigators, all of whom had extensive past experience in using the SCID. In addition, all clinical interviewers were provided with a detailed written protocol for conducting the clinical interview component of the study, along with a detailed user's guide for the PTSD module of the SCID. All clinical interviews were conducted blind to the results of the survey interview.

Since a key purpose of the clinical subsample was distinguishing true PTSD cases from true noncases, it was important that the subsample contain adequate numbers of both likely PTSD cases and likely noncases. Therefore a stratification procedure for selecting the sample was developed, guided by findings from the preliminary validation study. Under this procedure, all eligibles who appeared on the basis of their survey interview responses to be cases of PTSD, and a sample of those who appeared to be noncases, were selected for the clinical subsample. The sample of noncases was further stratified so as to maximize the likelihood of capturing false than among respondents, particularly among theater veterans, the relatively high response rates in both groups coupled with the relatively small disparity in the proportion of M-PTSD positives between respondents and nonrespondents suggests that nonresponse bias is not likely to be a major issue. Nevertheless, the clinical subsample analysis weights were adjusted to take account of the actual level of nonresponse.

III.. LOGIC AND IMPLEMENTATION OF THE COMPOSITE DIAGNOSIS PROCEDURE

A. Statement of the Problem

Thus the clinical subsample was designed to provide multimethod, multisource information on which careful PTSD diagnostic decisions could be made. Exhibit B-1 summarizes the PTSD indicators that were collected for clinical subsample respondents.

Given this rich information resource, the problem was one of using the available information to maximize the accuracy of the PTSD diagnoses for the clinical subsample respondents. First, among the indicators taken individually, the research team had highest confidence in the diagnosis made by a trained, experienced mental health professional made on the basis of a structured, diagnostic interview. However, we also recognized that there is some chance for error in *any* diagnostic procedure, and since we had multiple PTSD indicators available for clinical subsample respondents, we sought an alternative procedure that could take advantage of *convergence* among indicators to increase confidence in the diagnosis. That is, if forced to use only one indicator, we would choose the clinical interviewer's diagnosis, as we considered it to be the best *single* indicator. However, we believe that confidence in the ultimate diagnosis is increased when *multiple* indicators concur on the diagnosis.

Under a multiple indicator approach, the available PTSD indicators for each respondent are carefully reviewed. When the various PTSD indicators for a given individual all agree on the diagnosis, then the diagnostic decision is clear. Complications arise, however, when there is *disagreement* among the indicators. It is for this reason--because the PTSD indicators are not always in complete agreement--that some additional diagnostic decision rules procedure are required.

negatives (i.e., persons who appeared to be noncases on the basis of survey interview information but who were truly PTSD cases) by oversampling those with high scores on an index of exposure to combat trauma and those reporting high nonspecific psychological distress. A total of 403 Vietnam theater veterans were selected for the clinical subsample under these rules, of whom 344 (85.4%) were interviewed.

The original NVVRS design called for clinical interviews to be conducted only with Vietnam theater veterans. However, analyses conducted for the NVVRS preliminary report suggested that the false positive rate (i.e., the proportion of those who are indicated as PTSD cases who are in fact noncases) of the M-PTSD scale, which plays a critical role in formulating population prevalence estimates for era veterans and civilians, might be much higher among era veterans than theater veterans. If this were the case, then any comparison of PTSD prevalence rates among theater and era veterans based on the M-PTSD scale would be erroneous. Therefore it was decided that information about the diagnostic error rates for the M-PTSD scale and other measures among era veterans was critical to the ultimate credibility of the study's findings. Consequently, an era veteran clinical subsample was selected and fielded. Following rules analagous to those used to select theater veterans, 116 era veterans were selected for the subsample, of whom 94 (81.0%) were interviewed.

The potential for bias alway exists when data are not collected for every individual selected in the sample (i.e., when there is nonresponse). Although the response rates achieved among both theater and era veterans in the clinical subsample were quite high, the potential for nonresponse bias nonetheless still exists.

One way of assessing the potential impact of nonresponse on estimates from the clinical subsample is to examine the proportion of M-PTSD scale positives--i.e., the "apparent" PTSD cases--among the respondents and nonrespondents. If the M-PTSD positives were much more likely than the M-PTSD negatives (the "apparent" noncases) to be nonrespondents, then the potential for bias would be increased. Among theater veterans, 30.3 percent of respondents were M-PTSD positive, compared with 38.3 percent of nonrespondents; among era veterans 18.5 percent of respondents were M-PTSD positive, compared with 21.7 percent of nonrespondents. Thus, although the proportion of M-PTSD positives was somewhat higher among nonrespondents

Exhibit B-1

PTSD indicators available for clinical subsample respondents

Name	Description	Type	Source
M-PTSD	Mississippi Combat-Related PTSD Scale	Self report	Survey interview
MMPI-PTSD	MMPI PTSD Scale (Fairbank-Keane Scale)	Self report	Clinical interview
SCIDX	PTSD diagnosis from the SCID interview	Clinician judgment based on self report	Clinical interview
SXCTCURR	Number of PTSD symptoms reported as having occurred within the past 6 months	Interview self report	Survey interview
SRRS_INT	Intrusion subscale of the Stress Response Rating Scale--assesses the presence of signs/symptoms of intrusive thoughts	Clinician judgment based on observation	Clinical interview
SRRS_AVD	Avoidance subscale of the Stress Response Rating Scale--assesses the presence of signs/symptoms of avoidance	Clinician judgment based on observation	Clinical interview
SRRS_REA	Reactivity subscale of the Stress Response Rating Scale--assesses the presence of signs/symptoms of psychological reactivity	Clinician judgment based on observation	Clinical interview
IES_INT	Intrusion subscale of the Impact of Event Scale--assesses the presence of signs/symptoms of intrusive imagery during R's self-selected worst period	Booklet self-report	Clinical interview
IES_AVD	Avoidance subscale of the Impact of Event Scale--assesses the presence of signs/symptoms of avoidance during R's self-reported worst period	Booklet self-report	Clinical interview
ASSES_SC	Global Assessment Scale--assesses overall level of psychosocial functioning	Clinician judgment based on observation	Clinical interview

Thus the "problem" that must be resolved for the multiple indicator approach is: how should PTSD diagnostic decisions be made for those subjects for whom there is diagnostic disagreement among the PTSD indicators? Conducting a second clinical interview, or a full clinical review of all existing case material for purposes of "adjudication", are two possible solutions to this problem. However, these alternatives were ruled out because they could not be carried out within the study's time schedule. Therefore the NVVRS research team opted for a method that makes more complete use of the data that are already available. This method is called a "composite diagnosis" procedure because it combines information from a variety of sources in the diagnostic decision.

B. Logic of the Composite Diagnosis Procedure

The NVVRS composite diagnosis procedure is founded upon certain assumptions about the PTSD indicators. The most fundamental of these assumptions is that there is some degree of error associated with every indicator--i.e., none of the indicators is infallible. Second, although the degree of error associated with each of the indices is not known with certainty, it is possible to divide the indicators into "primary" and "secondary" groups on the basis of the degree of confidence that can be placed in each. We consider the M-PTSD scale, the MMPI PTSD scale, and the clinical interview PTSD diagnosis to be the clinical study's primary indicators.

We granted these indicators "primary" status because we have validity information about them from the NVVRS preliminary validity study (and, in the case of the M-PTSD and MMPI PTSD scales, from other sources in the research literature). In addition, we found them to be reliable as well. The internal consistency coefficient (Cronbach's alpha) for the M-PTSD scale in the NVVRS sample is .935, while the split-half reliability for the MMPI PTSD scale, corrected for attenuation, is .944 (raw coefficient=.894). Audio tapes of all SCID interviews were reviewed by one of the clinical co-principal investigators, and instances in which the reviewer noted either a clerical or clinical error were reviewed by all three. These reviews resulted in changing the SCID PTSD diagnosis for 10 of the 437 subjects (2.3%; 5 diagnoses changed from negative to positive, and 5 from positive to negative). A more formal reliability study of the clinical interview PTSD diagnosis, involving blind rescoring of the interview by two additional clinicians listening independently to the audio tape, is in process.

The composite diagnosis procedure begins by considering any subject for whom the three primary indicators are in complete agreement--i.e., all three indicate that the person is a current PTSD case or all three indicate that the person is not a current PTSD case--to be "settled" (decided). For the remainder of the subjects there is some level of discrepancy between the three primary indicators, and it is for the cases with a discrepancy that additional rules for case determination had to be developed.

We reasoned that the "best" way of settling the discrepant cases, given that a second clinical examination or a full clinical adjudication on all such cases was not feasible, was to devise a method that mirrored as closely as possible the process of clinical decisionmaking. We further reasoned that what a good clinician does when faced with discrepant primary diagnostic indicators is to seek to bring additional information to bear on the diagnostic decision. Therefore, we sought a reliable way of integrating information contained in our group of secondary PTSD indicators into the decisionmaking process.

Since we were uncomfortable with affording any of the individual secondary indicators equal status with the primary indicators, we sought a way of combining information from them. That is, we sought a method by which information from two or more secondary indicators could be combined to produce diagnostic decisions that were more accurate than decisions based on the individual indicators. We reasoned that clinical decisions are made in specific cases on the basis of past experience with "known" cases--i.e., by comparing the characteristics of a given case with characteristics of "known" cases seen in the past. Since we had available the best set of PTSD cases and noncases ever assembled--the subset for which our three primary indicators completely agree--we reasoned that we should use that information to our advantage. We could do so by examining whether the information contained in our secondary indicators could be combined in such a way that it would correctly classify the subset on which there is complete agreement of the primary indicators. That is, does the information in the secondary indicators tell us the same thing about the presence or absence of PTSD that the three primary indicators tell us when they all agree? If so, we could have confidence in using that information in the process of case determination where there was some discrepancy among the three main indicators.

Following this logic and using logistic regression as our method for combining indicators, we found that information from two of our secondary indicators could be combined in such a way that the diagnostic prediction from that combination agreed with the unanimous diagnosis of the three primary indicators 97.3% of the time (90.2% sensitivity, 98.9% specificity; model multiple R=.882). The two indicators which contributed significantly to this combination were the score on the SRRS intrusion subscale (a clinical judgment of the presence of symptoms of intrusive imagery, which many clinicians see as the hallmark of PTSD) and the number of current PTSD symptoms reported by the respondent in the survey interview. The fact that these indicators were both central to the PTSD diagnosis and were collected through different methods was seen as evidence of the construct validity of the combination.

Therefore, we decided to apply the method to all subjects in the clinical subsample, and to treat the diagnosis resulting from this combination as a "fourth" primary indicator. Further, we adopted a decision rule for case determination that considered as diagnostically settled all subjects for whom all four indicators agreed on the diagnosis and all subjects for whom three of the four indicators were in agreement.

The one exception to the "three out of four" rule was cases where the diagnosis from the "combined" indicator differed strongly (operationally defined as probability of caseness less than .25 or greater than .75) from the unanimous diagnosis of the three primary indicators. These subjects were left as "unsettled" at this stage, to assure that they not be settled prematurely. Also unsettled was the group of subjects for whom the four indicators split evenly, two indicating that the subject was a PTSD case and two indicating that he/she was not a case. Therefore, we searched for a method for making case determinations for these most seriously discrepant subjects. Since our first combination of secondary indicators "used up" only part of the information from the secondary indicators, we recognized that there was still considerable information about PTSD available that had not yet been brought to bear in the case determination process. Consequently, we sought a way to make use of this remaining information.

Remembering that the first model was based on an extremely "pure" gold standard (the "complete agreement" PTSD cases and noncases), we recognized that as a result of application of a second decision rule (that settled the subjects for whom three of four indicators pointed in the same direction) we now have an expanded set of settled cases that could be viewed as a new gold standard. This set included the original complete agreement cases and the newly settled three out of four cases. We conceptualized this group as a second generation gold standard, composed of the purest cases/noncases plus a group of slightly less "pure" cases/noncases[1]. We sought a method of combining the remaining PTSD information to replicate the case/noncase distinction defined by this second-stage gold standard.

To do so, we examined the ability of the remaining secondary PTSD indicators to replicate the diagnostic decisions made by the combination of four primary indicators for the subjects that were considered settled at this point (i.e., those for whom at least three of the four primary indicators agreed on the diagnosis). Again using logistic regression, we found that the diagnostic determination made by combining information from the indicators that had not yet been used agreed with the "settled" diagnosis 97.6% of the time (91.3% sensitivity, 98.8% specificity; model multiple R=.875). The indicators that contributed to this combination were the IES intrusion subscale, the Global Assessment Scale, indicators from the clinical interview suggesting that the person was a past (not current) PTSD case or a "subclinical" case (had significant symptoms but not the full syndrome), and an indicator of theater vs. era veteran status. The fact that the indicators contributing to the combination again represented a combination of methods and sources of information was seen as evidence of the construct validity of the procedure.

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[1] --If PTSD "caseness" is conceptualized as a continuum of PTSD intensity on which a binary case/noncase distinction is imposed by the psychiatric taxonomy, then our first generation gold standard might be viewed as containing only persons at the extremes of the continuum: pure cases and noncases. Adding to this group a set of persons for whom the case/noncase distinction was somewhat less clearcut may then be seen as adding some persons who fall closer to the middle of the continuum but who are still distinct enough to be clearly diffferentiated as either cases or noncases with good confidence (very high sensitivity and specificity). While in one sense this may be seen as "diluting" the gold standard, we prefer to think of it as creating a gold standard that more accurately reflects the characteristics of real-world PTSD cases and noncases.

Following our earlier logic, we applied this method to all of the subjects and treated its diagnostic indication as a "fifth" primary indicator. Remembering that the only cases left unsettled at this point were those for which the first four primary indicators were split evenly (two-two), we adopted a rule that accepted as settled (in the direction that three of the five indicators pointed) those subjects for whom this fifth indicator provided a strong indication (operationally defined as before) that the subject either was or was not a PTSD case. This rule left as unsettled those subjects for whom the first four indicators were evenly divided and the fifth was not decisive. In principle these are the most ambiguous cases, and we decided to make the case determination for these based on a thorough clinical review of all available interview material. Among the 437 clinical subsample respondents there were 9 such cases (2.1%), and the composite diagnosis for these subjects was the clinician's diagnostic assessment. In addition, six subjects whose diagnostic status could not be settled by the composite diagnosis procedure because one or more of the PTSD indicators was missing were also settled via this clinical adjudication procedure. The clinical review was undertaken independently by two expert clinicians (two of the clinical co-principal investigators), and any discrepancies between these independent assessments were decided on the basis of a case conference of the three clinical co-principal investigators.

C. Results of the Composite Diagnosis Procedure

A first question about the composite diagnosis process might be: how many subjects were settled at the different stages? For theater veterans, 48 percent (166/343) fell in the category of "complete agreement", and were thus immediately settled. An additional 21 percent (72/343) were settled by the "three or four out of four" rule, 26 (90/343) percent by application of the second stage model, and 4 (15/343) percent by clinical adjudication.

Another perspective on the composite diagnosis procedure is provided in Exhibit B-2, which shows the distribution of diagnostic patterns of the five main indicators and the corresponding composite diagnosis. This shows that for 57 percent (195 of 343) of theater veteran subjects, all five

Exhibit B-2

Distribution of 5-indicator patterns and correspondence with composite diagnosis (theater veterans only)

Pattern[1]	Composite PTSD Diagnosis: 0	1	Total Frequency
00000	163	0	163
00.00	16	0	16
00100	13	0	13
10000	13	0	13
10100	10	0	10
0000.	9	0	9
00010	5	0	5
00001	4	0	4
10010	3	0	3
0010.	2	0	2
00011	2	0	2
10.00	2	0	2
00.0.	1	0	1
00.01	1	0	1
0001.	1	0	1
00101	1	0	1
00110	1	0	1
00.1.	1	0	1
1100.	1	0	1
101..	1	0	1
01010	1	1	2
11000	2	1	3
10.10	1	1	2
01011	2	3	5
00111	1	1	2
10011	1	1	2
01.10	0	1	1
01.11	0	1	1
1101.	0	1	1
10101	0	1	1
01101	0	1	1
1011.	0	2	2
11010	0	2	2
11110	0	3	3
10110	0	4	4
11101	0	5	5
11011	0	5	5
11.11	0	6	6
10111	0	6	6
01111	0	7	7
11111	0	32	32
	258	85	343

1-Legend: 1=PTSD case
0=noncase
.=missing

Order of Indicators:
col 1=M-PTSD scale
col 2=SCID
col 3=MMPI PTSD scale
col 4=First stage model
col 5=Second stage model

indicators agreed. For another 30 percent (102/343), four of the five indicators agreed with the composite diagnosis diagnosis, and for 12 percent (40/343) three of five agreed (the remaining six subjects had one of the five main indicators missing).

A third perspective on the composite diagnosis procedure is provided in Exhibits B-3 and B-4, which show the mean scores on a variety of PTSD variables--some of which were used in the composite diagnosis procedure and some of which were not--for PTSD cases (B-3) and noncases (B-4). Means are shown at each of three stages of the composite diagnosis procedure: (1) for the complete agreement subjects, (2) for those settled by the "three or four of four" rule, and (3) for all subjects. The exhibits show clearly that, although the gap between the mean scores for PTSD cases and noncases narrows somewhat at each stage, the group means remain very different. For example, the mean score for the spouse M-PTSD scale (the spouse's report of the veteran's PTSD symptoms) for all composite diagnosis PTSD cases is 86.8, compared to a mean of 62.0 for all noncases (and compared to a mean of 99.0 for the complete agreement cases). This suggests that the PTSD cases and noncases are very different from one another at the aggregate level, both on variables that formed part of the basis of the composite diagnosis diagnosis and on PTSD variables that are independent of the composite diagnosis process.

D. Comparison of DSM-III-R Clinical and Composite Diagnoses with Alternative Diagnostic Rules

To assess the impact of using the DSM-III-R clinical PTSD diagnosis (i.e., the clinical diagnosis based on the SCID interview) versus the composite diagnosis on the study's diagnostic results, comparisons were made of the DSM-III-R clinical and composite diagnoses with those resulting from several alternative decision rules. These alternatives include the separate diagnoses of the other two primary indicators, a "best two out of three" rule (i.e., the diagnosis is decided in whichever direction at least two of the three primary indicators point), and a classification rule that gives preference among the three primary indicators to the diagnosis from the clinical interview (the SCID interview diagnosis is always taken as always correct, and subjects for whom the other 2 indicators disagree with

Exhibit B-3

Mean Profiles for Theater Veteran Best Estimate PTSD Cases on PTSD-Related Variables (Standard Deviations in Parentheses)

Variable	Complete Agreement PTSD Cases (n=38)	Three or Four of Four PTSD Cases (n=54)	Final PTSD Cases (n=85)
M-PTSD scale	114.3 (17.0)	107.8 (18.6)	103.4 (20.2)
MMPI PTSD scale	26.3 (6.9)	23.7 (8.8)	21.5 (9.1)
SRRS intrusion subscale	20.3 (11.2)	18.1 (10.6)	16.4 (10.0)
D-PTSD current Sx	5.9 (4.7)	5.4 (4.2)	4.2 (4.1)
IES intrusion subscale	25.6 (7.3)	24.9 (7.6)	25.0 (7.5)
SRRS reactivity subscale	15.7 (9.2)	15.2 (9.4)	13.2 (9.2)
Global assessment scale	6.0 (1.4)	6.2 (1.4)	6.4 (1.3)
Spouse M-PTSD scale	99.0* (19.3)	89.8** (24.4)	86.8*** (23.6)
PERI demoralization scale	2.12 (0.7)	1.99 (0.7)	1.82 (0.8)
IES avoidance subscale	27.7 (9.6)	27.9 (8.6)	27.1 (8.2)
SRRS avoidance subscale	17.2 (11.3)	16.0 (10.6)	14.4 (10.1)
D-PTSD lifetime Sx	8.7 (4.0)	7.9 (4.0)	7.0 (4.1)
SCID lifetime Sx	14.4 (2.6)	13.1 (4.0)	13.3 (3.7)
SCID current Sx	12.8 (3.1)	10.9 (4.7)	10.4 (4.4)

*n=26
**n=34
***n=56

Exhibit B-4

Mean Profiles for Theater Veteran Best Estimate
Noncases on PTSD-Related Variables
(Standard Deviations in Parentheses)

Variable	Complete Agreement Noncases (n=128)	Three or Four of Four Noncases (n=196)	Final Noncases (n=258)
M-PTSD scale	58.3 (10.9)	63.8 (14.0)	67.7 (16.6)
MMPI PTSD scale	3.3 (2.8)	5.2 (5.5)	6.3 (6.4)
SRRS intrusion subscale	1.1 (2.7)	1.7 (2.6)	2.7 (4.2)
D-PTSD current Sx	0.4 (0.9)	0.4 (0.8)	0.7 (1.6)
IES intrusion subscale	7.6 (7.9)	10.6 (9.1)	11.8 (9.3)
SRRS reactivity subscale	1.1 (3.0)	1.6 (3.2)	2.3 (4.2)
Global assessment scale	8.4 (0.8)	8.3 (0.9)	8.1 (1.0)
Spouse M-PTSD scale	57.4* (16.8)	59.5** (15.3)	62.0*** (17.3)
PERI demoralization scale	0.73 (0.5)	0.84 (0.5)	0.92 (0.6)
IES avoidance subscale	7.7 (8.8)	11.3 (10.2)	12.8 (10.4)
SRRS avoidance subscale	1.3 (2.6)	2.1 (3.7)	3.0 (5.4)
D-PTSD lifetime Sx	0.4 (0.9)	1.8 (2.6)	2.3 (3.0)
SCID lifetime Sx	1.7 (2.4)	3.8 (4.1)	4.6 (4.7)
SCID current Sx	0.6 (1.1)	1.5 (2.0)	2.0 (2.7)

*n=88
**n=131
***n=166

the SCID are left undiagnosed as "possible cases"). This latter rule is referred to as the "SCID dominant" rule.

Exhibits B-5 and B-6 show the correspondence of each of these alternatives with the DSM-III-R clinical diagnosis (B-5) and the composite diagnosis within the clinical subsample (unweighted). Also shown is the theater veteran prevalence estimate (prevalence of PTSD among the 42% of the theater veteran population who were eligible for the clinical subsample) that would result from each. These data show that the correspondence between the various alternatives is quite high: high sensitivities and specificities, and high values for Kappa (chance-corrected agreement). Except for the estimate based on the M-PTSD, there is also good agreement among the resulting prevalence estimates. The M-PTSD estimate is inflated because of its nonspecificity--i.e., the M-PTSD scale has a relatively high false positive rate relative to either the DSM-III-R clinical diagnosis or the composite diagnosis.

Exhibit B-5

Comparison of DSM-III-R Clinical (SCID) Diagnosis with Alternative Diagnostic Rules (Theater Veterans Only)

Alternative		DSM-III-R Clinical PTSD Diagnosis: 0	1	Sensitivity	Specificity	Kappa	Prevalence Estimate[1]
M-PTSD scale	0	222	17	77.3	82.8	.528	20.3
	1	46	58				
Composite	0	252	6	92.0	94.0	.821	14.8
	1	16	69				
MMPI PTSD scale	0	202	19	71.6	82.4	.478	15.7
	1	43	48				
Two out of three	0	221	7	89.6	90.2	.730	15.1
	1	24	60				
SCID dominant	0	240	0				11.9
	?	28	7				(4.9)
	1	0	66				

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[1] --Estimated PTSD prevalence in the clinical subsample eligible population.

Exhibit B-6

Comparison of Composite Diagnosis with Alternative Diagnostic Rules (Theater Veterans Only)

Alternative		Composite PTSD Diagnosis:		Sensitivity	Specificity	Kappa	Prevalence Estimate[1]
		0	1				
M-PTSD scale	0	224	15	82.4	86.8	.644	20.3
	1	34	70				
DSM-III-R clinical (SCID)	0	252	16	81.2	97.6	.821	13.8
	1	6	69				
MMPI PTSD scale	0	207	14	81.6	87.7	.649	15.7
	1	29	62				
Two out of three	0	222	6	92.1	94.1	.832	15.1
	1	14	70				
SCID dominant	0	238	2				11.9
	?	17	18				(4.9)
	1	3	63				

1--Estimated PTSD prevalence in the clinical subsample eligible population.

Appendix C: Prevalence Estimate Methodology

Formulation of estimates of PTSD prevalence were a central part of the planning of the NVVRS analyses. The research team conceptualized four general classes of methods by which the population prevalence estimates could be made. The simplest and least controversial of these was to make prevalence estimates based simply on the M-PTSD scale, the survey interview measure that had the best correspondence with the DSM-III-R clinical and composite diagnoses (and is therefore the "best" survey interview based measure). This method involves assigning a caseness cut-off to the M-PTSD scale, which is available for the entire survey interview sample, and estimating the proportion of persons in the groups of interest who are at or above the cut-off. The strength of this approach is that it is straightforward and provides estimates for which the standard error estimates are nonproblematic.

The major drawback of the unadjusted M-PTSD estimates is that we know from our clinical subsample findings that there is error in the PTSD diagnoses made solely on the basis of the M-PTSD scale. Taking either the DSM-III-R clinical diagnosis or the composite diagnosis as the gold standard, the false positive rate associated with the caseness cut-off (determined in the preliminary validation study) is higher than the false negative rate, potentially resulting in artificially high prevalence estimates. Additionally, the error rates are not constant across groups, thereby confounding cross-group comparisons (e.g., the false positive rate for era veteran males is more than twice that for theater veteran males).

These problems led us directly to our second set of estimates, which involve adjusting the M-PTSD scale estimates for bias. We "know" about the bias in the M-PTSD from the correspondence between it and the composite diagnosis within the clinical subsample. From the clinical subsample correspondence table of the M-PTSD and composite diagnosis we can estimate the Vietnam theater veteran population values for false positive and false negative rates through use of statistical adjustment procedures. These rates could then be used to "adjust" estimates based on the M-PTSD scale

A complication arises from the fact that the clinical subsample is a subsample selected from a nonrandom (though identifiable) subset of the total population--those living within reasonable commuting distance of the 28 SMSAs in which we conducted clinical interviews. Since the total population may differ from this subpopulation on any number of important characteristics, the correspondence table would need to be adjusted for those differences. Given that such adjustments could be made, the estimated population false positive and false negative rates could then be used to adjust the raw M-PTSD rates by subtracting out the false positives and adding back the false negatives to derive an estimate of the "true" prevalence.

In order to estimate the population false positive and false negative rates, prediction models were fit to the corresponding rates in the clinical subsample using as predictors only variables that were available for the full survey sample. Stepwise regression procedures were used to select model variables that satisfied two criteria, (1) their distributions differed for the portion of the survey sample that was eligible for the clinical subsample and the portion that was not and (2) they were significantly associated with the probability of being a false positive or false negative case. Separate logistic regression models were fit to each probability. The estimated prediction equation for false positives was applied to the respondents in the full survey sample with positive MPTSD, and a predicted probability of being a false positive case computed for each respondent. Similarly, the prediction equation for false negatives was applied to sample members with negative MPTSD, and a predicted probability of being a false negative case computed. Weighted averages of these predicted probabilities were produced for the survey population of theater veterans and the various subgroups of interest. These averages represent consistent estimates of the population false positive and false negative rates. Although we feel that this "adjusted" M-PTSD estimate is more accurate than the "raw" M-PTSD, calculation of the resulting standard error is problematic and was not carried out. However, it is clear that the standard error of the adjusted estimate is larger than that of the corresponding raw estimate.

An alternative approach provides a third class of estimates, which we refer to as "direct" estimates. Since we have a composite PTSD diagnosis for every respondent in the clinical subsample, by applying the appropriate clinical subsample and survey sample weights to the clinical subsample findings we would produce a direct estimate of the prevalence of PTSD in the population that was eligible for the clinical subsample (the roughly 42% of theater veterans living within reasonable commuting distance of our 28 clinical interviewers). This estimate is satisfying in the sense that it is a direct estimate of the best estimate diagnosis at the individual level, and yet unsatisfying because it is an estimate for a subpopulation which may differ in the distribution of many important characteristics from the population of interest. However, these "direct" estimates were computed to provide a basis for comparison of the other estimates.

Finally, a fourth class of estimates results from a somewhat different conceptualization of the problem. In this approach, the problem is formulated as: how can the composite diagnosis and the clinical DSM-III-R diagnosis, which are available only for clinical subsample respondents, be extended to the full survey interview sample? This method's answer is to develop prediction models of these diagnoses using as predictors only information that is available for all survey interview respondents. The parameters of these models are estimated using the clinical subsample, and the models are then applied to the full survey interview sample to produce predicted probabilities of caseness for every survey interview respondent, as in the prediction of false positive and negative rates. Variables were selected with stepwise procedures from the pool of those whose distributions differed across sample members eligible and not eligible for the clinical subsample, and that were significantly associated with the composite or DSM-III-R clinical diagnoses, respectively. Logistic regression models were fit for the clinical subsample, and the prediction equations applied to each respondent in the full sample in order to compute predicted composite and clinical DSM-III-R diagnoses. Weighted averages of these predicted probabilities of caseness were then produced for the survey population and subgroups of interest. The prevalence estimates resulting from this modeling effort are called "projected" because they represent the statistical projection of clinical subsample findings to the full veteran population.

Although PTSD diagnosis is a dichotomous variable, the logistic regression calibration models produce a conditional expected value for each respondent which can be interpreted as the probability of a positive diagnosis given the characteristics of the respondent as measured in the survey sample. To account for the added variability resulting from predicting PTSD diagnosis at the individual level, variances for the projected DSM-III-R clinical and projected composite diagnosis are based on a dichotomous variable (like PTSD diagnosis) generated from random Bernoulli trials with the parameter p equal to the predicted probability of a positive PTSD diagnosis for each respondent. The reported standard errors were obtained by averaging over 10 replications of this procedure.

Exhibit C-1 shows the prevalence estimates for Vietnam theater veteran subgroups that result from these various methods. As shown, the raw M-PTSD estimates are virtually always outliers relative to the estimates from the other five methods, which generally show good convergence. Since the logistic regression adjusted estimates are made for the full populations (and subpopulations) of interest, the projected clinical DSM-III-R and projected composite diagnosis estimates were selected for presentation.

Exhibit C-1

NVVRS PTSD Prevalence Estimates from Alternative Methods for Vietnam Theater Veteran Subgroups (standard errors in parentheses)

Theater Veteran Subgroup	Estimation Method					
	"Raw" M-PTSD	"Adjusted" M-PTSD	Direct DSM-III-R	Direct Composite	Projected DSM-III-R	Projected Composite
Males	20.9 (1.6)	16.5	13.9 (2.4)	14.8 (2.4)	14.7 (1.3)	15.3 (1.3)
Black	31.9 (2.8)	22.8	18.3 (4.3)	21.7 (4.7)	19.4 (2.3)	19.3 (2.3)
Hispanic	23.2 (3.0)	30.2	22.9 (5.1)	29.8 (6.3)	23.2 (3.3)	30.9 (3.8)
White/ other	19.3 (1.8)	14.8	12.4 (2.9)	12.4 (2.9)	13.6 (1.5)	13.8 (1.5)
Hi stress exposure	49.0 (3.7)	40.7	43.4 (7.4)	44.5 (7.4)	30.8 (3.2)	38.7 (3.5)
Lo/mod exposure	11.6 (1.5)	8.5	5.8 (2.0)	6.6 (2.1)	9.3 (1.3)	7.5 (1.2)
Females	8.9 (1.4)	8.4	7.9 (2.8)	6.8 (3.4)	8.3 (1.4)	10.0 (1.5)
Hi stress exposure	19.2 (3.1)	17.4	6.8 (2.4)	8.1 (3.7)	13.8 (2.8)	20.4 (3.1)
Lo/mod exposure	2.2 (0.9)	2.6	8.6 (3.9)	6.1 (3.1)	4.7 (1.3)	3.1 (1.0)
CDC/VES Experience	23.0	18.1	14.1 (4.0)	15.3 (4.1)	15.2 (2.3)	15.5 (2.1)

Legend: "Raw" M-PTSD = survey interview based M-PTSD estimates
"Adjusted" M-PTSD = raw M-PTSD estimates corrected with estimates of false positive and negative rates
Direct DSM-III-R = clinician-assessed rate in clinical subsample eligible subpopulation
Direct Composite = composite diagnosis rate in clinical subsample eligible subpopulation
Projected DSM-III-R = predicted clinician-assessed rate in full population
Projected Composite = predicted composite diagnosis rate in full population

Appendix D: Assessment of War Zone Stress Exposure

Even the earliest research studies of participants in the Vietnam war suggested that actual combat experience and exposure to other war stressors, rather than service in Southeast Asia or the military *per se*, were the principal factors predicting later adjustment. Additionally, prior studies have found that the more differentiated the measure of combat or war stress used, the more likely such a relationship will be found. Recent work by Laufer and his colleagues (1984; Yager et al., 1984), for example, demonstrates that: (1) different psychological outcomes are associated with different elements of war stress (e.g., combat exposure versus exposure to abusive violence), (2) the impacts of different elements of war trauma are not always parallel or cumulative, and (3) the impacts may differ among subgroups of the veteran population. Hence, a basic assumption underlying the NVVRS was that the phenomenon of war trauma is multidimensional and that "no summary concept and measure [such as a undimensional scale of combat exposure] can adequately encapsule the variegated nature of war stress" (Laufer et al., 1984:77). Moreover, with the exception of items necessary to describe adequately the full range of war zone stressors to which female theater veterans were exposed, the basic concepts and measures required to conduct a multidimensional assessment of combat and war zone stress exposure were already represented in the research literature and were adapted for use in the NVVRS. Although in our view the precise dimensions required to specify fully a multidimensional model of Vietnam war stress must be established empirically, such measures were compiled within eight broad content areas that recent research suggests should be included in such a model:

- General indicators of degree of involvement in combat based on both records and self-report, such as Vietnam-Era service, stationed in Vietnam, period of service in Vietnam, type of unit, unit location, type of duty, etc.;
- Exposure to stresses of serving in Vietnam other than combat;
- Specific dimensions of combat exposure or involvement, including extent, type, and frequency of exposure to enemy fire, degree of

involvement in engaging the enemy, and degree of exposure to injury and death of American soldiers;

- Exposure to and participation in the injury or death of Vietnamese civilians or abusive violence;
- Degree of perceived risk, threat, or danger to life and limb;
- Extent and nature of positive war zone experiences, and;
- Aspects of war stress of particular relevance to nurses, medics, and others assigned to work with the dead and dying.

It was assumed that a comprehensive assessment of Vietnam war stress must assess each of these broad dimensions to at least some degree, either as empirically distinct or as aspects included within a broader measure to describe adequately the war experiences of all participants.

In our overall assessment of war zone stress exposure almost 100 items representing these broad dimensions were subjected to principal components analyses to identify ways of combining specific experiences such that the important underlying dimensions of war zone stress were appropriately represented. These analyses were conducted on weighted correlation matrices, separately for male and female Vietnam theater veterans, using a varimax rotation and scree plots of eigenvalues (cf., Cattell and Vogelman, 1977) to determine the appropriate number of components to be examined. These analyses resulted in the identification of four basic clusters of items for males and six for females, along with a few individual items not clearly aligned with any of these.

For men, correlations of items within each of the clusters were examined separately for blacks, Hispanics, and white/others to see if the patterns of relationships were similar within each of these subgroups. In general, they were, although some of the items showed substantial numbers of low or nonsignificant correlations with other items in their respective clusters for one or more subgroups, primarily due to little or no variation and/or the presumed greater concentration of certain experiences in certain subgroups. Other than those showing scattered and nonsystematic patterns of this sort, four items in particular were problematic for one or more subgroups: (a) "[how often one flew] fixed-wing aircraft on missions over Vietnam, Laos, and/or Cambodia" (all, but especially blacks and Hispanics); (b) "how often...part of a river patrol of gunboat crew" (white/other); (c) "how often...part of a land or naval artillery unit which fired on the enemy" (white/others and blacks); and (d) "how often did you find yourself in any other life-threatening situations" (Hispanics). Ultimately, all four of these items were retained, however, because it was felt that, while they may not be consistently correlated with other measures of combat experience or exposure for all groups, they clearly still capture an important component of the war zone experience for many theater veterans. Similarly, although one item--being a prisoner of war (POW)--failed to load on any cluster (due to its low incidence), it was retained as an individual item. Three other items were dropped, one due to virtually total redundancy with an item that was retained and two others (months served and periods of duty in or around Vietnam) because they were too general to align themselves on any particular cluster.

Of the 97 items in the original set, 94 were thus retained for men in the following five groups including the four original clusters and one individual item:

(1) Exposure to Combat (CBT): 48 items, including receipt of personal combat awards or medals in Vietnam; type of duty in Vietnam (i.e., combat, combat support, etc.); exposure to danger and risk of casualty; self-described exposure to combat (i.e., light, moderate, heavy); how often in danger of being killed or wounded; how often in relatively unsafe or hostile territory; how often fly helicopter missions over Vietnam, Laos, or Cambodia; how often responsible for taking care of and/or evacuating casualties; how often received small arms fire from the enemy; how often encountered mines and booby traps; how often unit engaged in firefight with the enemy; how often fired weapon at the enemy; how often saw enemy/Americans being killed or wounded; ever wounded or injured in combat; and how often personally killed enemy personnel.

(2) Exposure to Abusive Violence and Related Conflicts (AVC): 24 items, including degree of involvement in torturing, wounding or killing hostages or POWs; involvement in mutilation of bodies of enemy or civilians; witnessed or involved in situation where women, children, or old people were injured or killed by Americans or South Vietnamese soldiers; personally saw or heard about an American soldier being tortured by the enemy; helping someone who asked to be allowed to die; and knew Americans who were casualties of "friendly fire."

(3) Deprivation (DPR): 12 items, including how often experienced not having shelter from the weather, enough water, adequate food, adequate equipment or supplies; how often physically fatigued or emotionally worn out/exhausted; how unpleasant found bad climate, loss of sleep, insects, disease, and filth.

(4) Loss of Meaning and Control (LMC): 9 items, including how unpleasant found sense of purposelessness, not counting as an individual, feeling out of touch with rest of world, loss of freedom of movement.

(5) Prisoner of War (POW): 1 item measure assessing ever having been a prisoner of war in or around Vietnam.

For women, correlations of items within each cluster were examined only for the total sample. Within clusters, few items showed consistent nonsignificant correlations with others in the same set, so that none were considered for deletion. However, the same three items deleted for males due to their redundancy or nonalignment with any component were also deleted for females, along with seven others. Three of these literally had no variation among female theater veterans (i.e., no women reported being part of a land or naval artillery unit, experiencing hand-to-hand combat, or wounding or killing people they weren't sure were enemy) and four others (volunteering for special jobs, such as a medic, special forces, or LRPP; being part of a river patrol or gunboat crew; having personally killed enemy personnel; and "letting buddies down" in a combat situation), also of little apparent relevance or meaning for women veterans in Vietnam, were not related to any of the primary clusters. Two other "rare event" items, although they did not align themselves with any particular cluster, were nevertheless retained as individual items--being a prisoner of war (POW) and having received a combat medal (MDL).

From the 87 items retained from the original set, the following eight groups were formed for female Vietnam theater veterans, including the original six clusters and two individual items:

(1) Exposure to Wounded and Dead (EWD): 20 items, including how often took care of people who later died; saw Americans (enemy) after wounded in combat; responsible for taking care of and/or evacuating casualties; exposed to sight, smell, or sound of dead and dying people; felt personally responsible for life and death decisions; felt emotionally worn out or exhausted; not able to help the wounded and dying as much as you wanted.

(2) Exposure to Enemy Fire (EEF): 27 items, including exposure to danger and risk of casualty; self-described exposure to combat (i.e., light, moderate, heavy); how often under enemy fire, in danger of being killed or wounded, in relatively unsafe or hostile territory, received incoming fire from enemy artillery, rockets and/or mortars, received sniper fire and/or sapper attacks, in a vehicle disabled by enemy fire.

(3) Direct Combat Involvement (DCI): 11 items, including how often fired a weapon in a combat situation; how often saw Vietnamese (or other enemy) being killed or wounded; ever kill or thought you killed someone; witnessed or involved in situations where women, children or old people, Vietnamese prisoners or civilians, were injured or killed.

(4) Exposure to Abusive Violence (EAV): 10 items, including personally saw or heard about American soldiers tortured by enemy or bodies of dead Americans mutilated by enemy; degree of involvement in torturing, wounding, or killing civilians, hostages or prisoners of war, mutilation of bodies of enemy or civilians.

(5) Deprivation (DPR): 10 items, including how often experienced not having enough water; adequate food, shelter from the weather; how unpleasant found bad food and climate; insects, disease, and filth; lack of privacy.

(6) Loss of Meaning and Control (LMC): 7 items, including how unpleasant found sense of purposelessness, not counting as an individual, feeling out of touch with rest of world.

(7) Prisoner of War (POW): 1 item measure assessing ever having been a prisoner of war in or around Vietnam.

(8) Received Combat Medal (MDL): 1 item assessing receipt of any combat medal for Vietnam service.

Based on the items retained in these clusters, 13 indices were created--five for men and eight for women. Except for the single item measures, these indices were created by taking the mean of the items retained in each cluster (allowing up to half of the items to be missing) multiplying the result by 100, and rounding to the nearest integer. Since most of these items were Likert scales with responses ranging from 1 to 5, the theoretical range of the resulting indices was 100-500 (except for the "abusive violence" measures, on which several items were scored from 0 to 5). The weighted correlations among these indices and their internal consistency reliabilities (coefficient alpha) are presented in Tables D-1 and D-2 for men and women, respectively.

D-6

Table D-1

Five Indices of War Zone Stress Exposure for Male Vietnam Theater Veterans:
Numbers of Items, Internal Consistency Reliabilities, Intercorrelations, and Relationships to PTSD Symptoms

War Zone Stress Index	No. of Items	Reliabilities	Intercorrelations CBT	AVC	DPR	LMC	POW
Exposure to Combat (CBT)	48	.887	1.00				
Exposure to Abusive Violence and Related Conflicts (AVC)	24	.904	.798	1.00			
Deprivation (DPR)	12	.873	.729	.664	1.00		
Loss of Meaning and Control (LMC)	9	.872	.429	.414	.632	1.00	
Prisoner of War (POW)	1	---	.048	.044	.033	-.005	1.00
Mississippi Scale for Combat-Related PTSD (M-PTSD)	35	.937	.466	.583	.518	.482	.006

Table D-2

Eight Indices of War Zone Stress Exposure for Female Vietnam Theater Veterans:
Numbers of Items, Internal Consistency Reliabilities, Intercorrelations, and Relationships to PTSD Symptoms

War Zone Stress Index	No. of Items	Reliabilities	Intercorrelations							
			EWD	EEF	DCI	EAV	DPR	LMC	POW	MDL
Exposure to Wounded and Dead (EWD)	20	.925	1.00							
Exposure to Enemy Fire (EEF)	27	.887	.471	1.00						
Direct Combat Involvement (DCI)	11	.704	.326	.443	1.00					
Exposure to Abusive Violence (EAV)	10	.733	.500	.431	.400	1.00				
Deprivation (DPR)	10	.795	.521	.502	.286	.430	1.00			
Loss of Meaning and Control (LMC)	7	.830	.349	.238	.157	.330	.537	1.00		
Prisoner of War (POW)	1	---	.037	.143	-.042	.030	.144	.031	1.00	
Received Combat Medal (MDL)	1	---	.043	.057	.127	.174	.057	.062	.104	1.00
Mississippi Scale for Combat-Related PTSD (M-PTSD)	35	.924	.311	.349	.359	.449	.434	.414	.203	.081

As shown in Tables D-1 and D-2, the reliabilities of the multi-item measures are moderate to high and the correlations among them also moderate to high, suggesting some degree of potential redundancy or overlap. In contrast, the single item measures--Prisoner of War (POW) and Received Combat Medal (MDL)--bear little or no relationship to the other measures, due primarily to their extremely skewed distributions. With the exception of POW for males and MDL for females, however, each of these measures is at least moderately correlated with PTSD symptomatology, as represented by the Mississippi Scale for Combat-Related PTSD (M-PTSD). Due to the manifest content of the Loss of Meaning and Control (LMC) indices, however, it was judged to partly confound exposure to stressors and reactions to such (i.e., symptoms of alienation). Thus, in further analyses designed to derive a single overall summary measure of war zone stress exposure, it was decided to drop these indices for both males and females. Each of the remaining measures--four for men and seven for women--were subjected to a second order principal components analysis to determine whether they could be combined into a single overall measure of exposure to war zone stress. These analyses indicated a single component for males and two for females. However, the eigenvalue for the second component for women was only 1.08 (versus 2.80 for the first), and all measures had loadings of .65 or higher on the first factor, except for POW and MDL, which had even lower loadings on the second factor. Therefore, a general index representing "overall war zone stress" was created as a weighted linear combination (factor score) of these four and seven specific indices for males and females, respectively. Weighted correlations of this overall index with PTSD symptomatology, as represented by the M-PTSD scale, were .575 and .516 for males and females, respectively.

This war zone stress index is a continuous measure, and thereby suitable for correlation and regression analyses, but there is good reason to believe that the relationship between war zone stress and PTSD symptoms (and other psychological problems) may not be wholly a linear one. It is quite plausible, for example, that there is a threshold effect for war zone stress, i.e., negative outcomes are likely to occur after this threshold is reached and not increase significantly beyond the threshold. Moreover, for ease of presentation, it is desirable to identify groups of Vietnam theater veterans who are relatively "high" on this measure, versus those who are relatively "low." It is not clear, however, whether the goal of this dichotomization should be to distinguish those "high" from "not high" on war zone stress, or to distinguish those who are clearly "low" from "not low" on war zone stress, as implied by the concept of a "threshold" noted above.

Rather than making this decision arbitrarily, it was decided to examine the extent to which different "cutoff" scores on the war zone stress index were able to distinguish those relatively high from those relatively low on the component war zone stress indices from which the factor scores were derived. How well, for example, would a 50-50 split on the war zone stress factor distinguish those high and low on Exposure to Combat (CBT) or Exposure to Wounded and Dead (EWD), two of the principal component indices for males and females, respectively? The results of these comparisons are presented in Tables D-3 and D-4, where the cutoff scores examined range from 50 percent high/50 percent low (based on the weighted frequency distribution) to 25 percent high/75 percent low for males, and from 67 percent high/33 percent low to 25 percent high/75 percent low for females. In addition, for each cutoff score an indicator of "discriminatory power" is provided in the form of the percentage of cases classified "low" with an index value below the mean for those classified "high" and the percentage of cases classified "high" with an index value above the mean for those classified "low." As shown in Table D-3, the "power of discrimination" for each of the alternative cutoff points is excellent for each of these measures, except for the highly-skewed POW item. Moreover, the rounded actual means (tabled means divided by 100) are identical for all of these comparisons, except for Exposure to Combat (CBT), where the 75/25 split is somewhat better than the others, indicating a typical response of "rarely" versus "often" for the low and high groups, respectively.

For women, Table D-4 indicates somewhat greater variability among the several cutoff scores, with a comparison of rounded actual means indicating that the "low threshold" cutoffs (33/67 and 40/60) do slightly better than the others on Exposure to Enemy Fire (EEF), while the 50/50 cutoff does somewhat better at distinguishing cases "low" and "high" on Exposure to Wounded and Dead (EWD). However, the rounded actual means for

Table D-3

Means (Weighted), Standard Errors, and Discriminatory Power for the Four War Zone Stress Component Indices
for Males Based on Alternative High-Low Cutoff Points on the War Zone Stress Factor Score

War Zone Stress Factor Cutoff (Based on Weighted Distribution)	Unweighted N	War Zone Stress Index							
		Exposure to Combat		Exposure to Abusive Violence & Rel. Conflicts		Deprivation		Prisoner of War	
		Mean (Std. Err.)	% < > Mean (H/L)	Mean (Std. Err.)	% < > Mean (H/L)	Mean (Std. Err.)	% < > Mean (H/L)	Mean (Std. Err.)	% < > Mean (H/L)
OVERALL	1,191	241 (3.4)	—	154 (2.5)	—	251 (2.8)	—	1.02 (.01)	—
[RANGE]		[104-473]		[76-471]		[100-500]		[1.00-5.00]	
Low (50%)	471	170 (2.5)	100.0	105 (1.4)	100.0	194 (2.4)	99.4	1.00 (.00)	100.0
High (50%)	720	308 (3.3)	99.2	200 (3.3)	97.1	303 (3.1)	98.3	1.03 (.02)	0.8
Low (60%)	586	180 (2.4)	99.9	111 (1.5)	99.8	204 (2.4)	98.7	1.00 (.00)	100.0
High (40%)	605	328 (3.0)	99.6	214 (3.7)	98.1	316 (3.4)	97.9	1.04 (.02)	1.1
Low (67%)	665	189 (2.7)	99.4	116 (1.6)	100.0	211 (2.4)	98.2	1.00 (.00)	100.0
High (33%)	526	340 (2.9)	99.9	227 (4.0)	98.4	326 (3.5)	97.5	1.06 (.03)	1.3
Low (75%)	781	201 (2.9)	99.6	122 (1.7)	99.9	218 (2.4)	98.2	1.01 (.01)	99.8
High (25%)	410	353 (3.1)	100.0	245 (4.4)	99.2	341 (3.8)	98.6	1.04 (.03)	1.1

Table D-4

Means (Weighted), Standard Errors, and Discriminatory Power for the Seven War Zone Stress Component Indices
For Females Based on Alternative High-Low Cutoff Points on the War Zone Stress Factor Score

War Zone Stress Factor Cutoff (Based on Weighted Distribution)	Unweighted N	War Zone Stress Index: Exposure To Wounded and Dead, Mean (Std. Err.)	Exposure To Wounded and Dead, % < > Mean (H/L)	Exposure To Enemy Fire, Mean (Std. Err.)	Exposure To Enemy Fire, % < > Mean (H/L)	Direct Combat Involvement, Mean (Std. Err.)	Direct Combat Involvement, % < > Mean (H/L)	Exposure To Abusive Violence, Mean (Std. Err.)	Exposure To Abusive Violence, % < > Mean (H/L)	Deprivation, Mean (Std. Err.)	Deprivation, % < > Mean (H/L)	Prisoner of War, Mean (Std. Err.)	Prisoner of War, % < > Mean (H/L)	Received Combat Medal, Mean (Std. Err.)	Received Combat Medal, % < > Mean (H/L)
OVERALL	432	300 (4.4)	—	177 (2.2)	—	114 (1.4)	—	118 (3.0)	—	254 (2.9)	—	1.03 (.02)	—	1.24 (.05)	—
[RANGE]		[100-480]		[100-337]		[100-327]		[29-320]		[100-440]		[1.00-5.00]		[1.00-5.00]	
Low (33%)	145	212 (5.8)	97.4	142 (1.9)	98.7	102 (0.6)	97.8	76 (2.7)	94.4	205 (3.3)	95.4	1.00 (.00)	100.0	1.09 (.05)	97.8
High (67%)	287	342 (3.9)	96.4	194 (2.5)	92.9	119 (2.1)	45.6	137 (3.8)	82.7	278 (3.2)	91.7	1.04 (.03)	1.0	1.32 (.06)	7.9
Low (40%)	177	227 (5.7)	95.7	147 (1.9)	96.2	102 (0.5)	98.2	80 (2.5)	94.2	298 (3.0)	96.4	1.00 (.00)	100.0	1.07 (.04)	98.2
High (60%)	255	347 (4.2)	95.6	198 (2.6)	91.4	121 (2.3)	49.6	141 (4.2)	86.1	294 (3.3)	95.4	1.05 (.03)	1.2	1.35 (.07)	8.8
Low (50%)	213	240 (5.2)	96.2	151 (2.5)	92.9	103 (0.5)	98.1	82 (2.5)	97.7	217 (3.2)	95.6	1.02 (.02)	99.5	1.08 (.04)	98.0
High (50%)	219	358 (3.9)	95.1	203 (2.8)	93.9	124 (2.6)	46.1	151 (3.7)	91.4	291 (3.7)	95.1	1.04 (.03)	0.9	1.40 (.08)	10.1
Low (60%)	258	252 (4.8)	97.2	155 (2.2)	96.1	103 (0.5)	97.7	88 (2.5)	95.8	225 (3.0)	91.9	1.02 (.02)	99.6	1.09 (.04)	97.7
High (40%)	174	370 (4.1)	95.4	210 (3.2)	95.4	128 (3.2)	42.6	160 (4.2)	94.0	297 (4.2)	94.2	1.05 (.04)	1.2	1.46 (.10)	11.6
Low (67%)	289	262 (4.7)	94.2	158 (2.0)	96.5	104 (0.5)	97.3	92 (2.4)	96.6	230 (2.9)	92.3	1.01 (.00)	99.7	1.12 (.04)	96.9
High (33%)	143	375 (4.5)	95.7	216 (3.5)	96.6	132 (3.7)	36.6	167 (4.7)	88.1	302 (4.8)	90.8	1.06 (.05)	1.4	1.48 (.11)	12.1
Low (75%)	324	271 (4.6)	93.4	162 (2.0)	95.3	105 (0.6)	98.6	95 (2.4)	97.2	235 (2.4)	91.6	1.01 (.01)	99.7	1.15 (.04)	96.4
High (25%)	108	383 (4.9)	95.5	223 (4.1)	95.6	139 (4.5)	31.0	179 (5.5)	90.3	310 (5.7)	91.7	1.07 (.06)	1.9	1.53 (.13)	13.2

the former (EEF) indicate a typical response of "never" versus "rarely," while for the latter (EWD) they reflect an average difference of "rarely" versus "often." By contrast, a comparison of the percentages indicating discriminatory power suggests that a cutoff score reflecting 60 percent "low" versus 40 percent "high" might be preferable.

Although these analyses were not nearly as definitive as we had anticipated, they suggested a cutoff score in the 75/25 range for males and the 60/40 range for females. In a further effort to ensure that "highs" would really be "high" and "lows" low, two more direct alternative summary measures of war zone stress exposure were derived, one for males and one for females. For males, a case was defined as "high" if any one of the following cutoff scores was equaled or exceeded: (1) Exposure to Combat (350, mean between "sometimes" and "often"); (2) Deprivation (350); (3) Exposure to Abusive Violence and Related Conflicts (250); (4) Prisoner of War (Yes). For females, a case was defined as "high" if any one of the following cutoff scores was equaled or exceeded: (1) Exposure to Wounded and Dead (350); (2) Deprivation (350); (3) Exposure to Enemy Fire (250, mean between "rarely" and "sometimes"); (4) Exposure to Abusive Violence (250); (5) Direct Combat Exposure (200); (6) POW (Yes). In each case, those that did not meet these criteria were classified as "low."

The weighted distributions for these "alternate" measures of war zone stress exposure are 20.7 percent "high" and 79.3 percent low for men and 37.8 percent "high"/62.2 percent "low" for women. Given these distributions, it was assumed that a cutoff score on the war zone factor score in the 67/33 or 75/25 range for males and 50/50 or 60/40 range for females would be required to capture those cases classified "high" on these alternate measures. The relationships between these different measures of war zone stress are presented in Table D-5. For males, a cutoff score of 75 percent "low" and 25 percent "high" results in a distribution whereby 92 percent of those classified as "high" on the alternative measure are also classified "high" on the factor-based measure compared to less than 8 percent of those classified as "low." For women, the choice is less straightforward, but the balance achieved by the 60/40 measure appears preferable to a minimization of "false negatives" at the expense of "false positives" when a 50/50 split is used. With a cutoff score of 60 percent "low" and 40 percent "high," 87.5 percent of those

Table D-5
Relationships (Weighted) of Alternate Measure of War Zone Stress Exposure to
the Primary War Zone Stress Factor Score Using Alternative High-Low Cutoff Scores

War Zone Stress Factor Cutoff Scores	Unweighted N	Alt. War Zone Stress Exposure (Row %)			Alt. War Zone Stress Exposure (Col. %)	
		Low-Moderate	High	Total	Low-Moderate	High
MALES:						
War Zone 67						
Low (67%)	677	99.1 (0.5)	0.9 (0.5)	100.0	83.7 (1.6)	3.1 (1.5)
High (33%)	512	39.3 (3.2)	60.7 (3.2)	100.0	16.3 (1.6)	96.9 (1.5)
Total	--	--	--	--	100.0	100.0
War Zone 75						
Low (75%)	783	97.6 (0.7)	2.4 (0.7)	100.0	92.1 (1.2)	8.8 (2.3)
High (25%)	406	24.9 (3.3)	75.1 (3.3)	100.0	7.9 (1.2)	91.2 (2.3)
Total	--	--	--	--	100.0	100.0
Unweighted N	1,189	--	--	--	843	346
FEMALES:						
War Zone 50						
Low (50%)	217	93.9 (1.6)	6.1 (1.6)	100.0	75.8 (2.7)	8.1 (2.1)
High (50%)	215	30.2 (3.2)	69.8 (3.2)	100.0	24.2 (2.7)	91.9 (2.1)
Total	--	--	--	--	100.0	100.0
War Zone 60						
Low (60%)	262	90.5 (1.8)	9.5 (1.8)	100.0	87.5 (2.1)	15.2 (2.8)
High (40%)	170	19.5 (3.1)	80.5 (3.1)	100.0	12.5 (2.1)	84.8 (2.8)
Total	--	--	--	--	100.0	100.0
Unweighted N	432	--	--	--	270	162

classified "low" on the alternate measure and 84.8 percent of those classified "high" are similarly categorized on the war zone factor measure. As a result of these analyses, it was decided that the general measure of war zone stress to be used in the NVVRS would be the 25 percent "high" cutoff for men and the 40 percent "high" cutoff for women. However, the "alternate" measure was also retained, so that relationships between war zone stress and certain key outcome measures could be examined with both measures, to assure that such relationships are not measure-specific.

In addition, since the derived measure of war zone stress exposure is based solely on self-report measures, it was important to examine this measure in relation to somewhat more objective indicators to independently establish its validity. Thus, the relationship between this measure and several indicators abstracted from military records were examined, as shown in Table D-6. The first indicator is based on a recoding of the primary military occupation (MOS) at discharge into those regarded as "tactical" (i.e., infantry, armor, artillery, combat engineering) or "nontactical." It is important to note that occupations in this category necessarily vary somewhat by branch of service and for officers as opposed to enlisted men. Moreover, because it is an indicator of MOS at discharge (rather than the "primary" or "duty" MOS while in Vietnam) and because of the nature of the Vietnam war, this is at best a crude indicator of potential exposure to war zone stress. Nevertheless, the relationships observed, especially for Army and Marine Corps enlisted men provide relatively strong support for the validity of the war zone stress measure. Similarly, for women, a distinction between nursing and non-nursing occupations is strongly related to the war zone stress measure. The third indicator represents a slightly more sophisticated recoding of the MOS at discharge for men, recognizing that certain military occupations, though officially "nontactical," carry with them a higher than average risk of exposure to war stress. Thus, in addition to those with a tactical MOS, certain others were coded "high" (e.g., medical corpsmen, graves registration) while several others were elevated to "moderate" (e.g., radio telephone operators, track mechanics, field wiremen). This revised "MOS by Probability of Exposure" variable bears a strong relationship to the self-report war zone stress measure. Similarly, each of the remaining

Table D-6

Relationships of Selected Military Record Indicators and the Self-Report Measure of War Zone Stress Exposure

	Males			Females		
Indicator	Unweighted N	% High Stress Exp.	Std. Error	Unweighted N	% High Stress Exp.	Std. Error
Military Occupation (MOS) at Discharge (By Rank and Service)						
Army Enlisted Tactical	248	52.3	(4.7)	—	—	—
Army Enlisted Nontactical	394	23.7	(2.8)	—	—	—
Army Officer Tactical	16	32.1	(12.4)	—	—	—
Army Officer Nontactical	18	7.5	(7.2)	—	—	—
Air Force Enlisted Tactical	1	—	—	—	—	—
Air Force Enlisted Nontactical	136	11.1	(3.2)	—	—	—
Air Force Officer Tactical	8	—	—	—	—	—
Air Force Officer Nontactical	4	—	—	—	—	—
Marine Enlisted Tactical	109	63.6	(8.3)	—	—	—
Marine Enlisted Nontactical	58	30.5	(8.0)	—	—	—
Marine Officer Tactical	3	—	—	—	—	—
Marine Officer Nontactical	1	—	—	—	—	—
Navy Enlisted Tactical	22	22.9	(10.3)	—	—	—
Navy Enlisted Nontactical	166	8.8	(2.6)	—	—	—
Navy Officer Tactical	3	—	—	—	—	—
Navy Officer Nontactical	7	—	—	—	—	—
Nursing MOS (Females Only)						
Non-Nurse	—	—	—	70	17.1	(4.6)
General Nursing	—	—	—	122	40.4	(4.9)
Nursing Specialist	—	—	—	240	46.0	(3.3)

Table D-6 (Continued)

	Males			Females		
Indicator	Unweighted N	% High Stress Exp.	Std. Error	Unweighted N	% High Stress Exp.	Std. Error
MOS By Probable Exposure to War Zone Stress (Males)						
Low	619	13.5	(1.7)	—	—	—
Moderate	168	32.9	(4.7)	—	—	—
High	402	49.8	(3.8)	—	—	—
Branch of Service at Discharge						
Air Force	151	10.4	(2.9)	58	26.6	(6.3)
Army	673	31.2	(2.4)	300	43.5	(2.9)
Navy or Coast Guard	199	9.9	(2.5)	22	47.5	(10.8)
Marine Corps	191	48.6	(5.8)	3	—	—
Received Combat Medal						
Yes	398	43.0	(3.6)	77	41.4	(5.7)
No	814	19.9	(1.8)	304	40.9	(3.0)
Received Purple Heart						
Yes	206	70.3	(5.7)	2	—	—
No	1007	21.5	(1.6)	379	40.7	(2.6)
Service Connected Physical Disability						
None	951	23.7	(1.7)	352	39.0	(2.7)
Low (0-20%)	156	36.1	(5.7)	31	48.4	(9.1)
High (30-100%)	110	41.0	(6.6)	49	42.2	(7.2)

Table D-6 (Continued)

Indicator	Males			Females		
	Unweighted N	% High Stress Exp.	Std. Error	Unweighted N	% High Stress Exp.	Std. Error
Year Began 1st Vietnam-Related Tour						
1965 or earlier	161	19.2	(3.8)	19	44.5	(11.6)
1966	167	26.5	(4.3)	40	30.0	(8.1)
1967	269	28.7	(3.8)	68	43.3	(6.1)
1968	244	30.5	(3.9)	94	46.3	(5.2)
1969	177	38.3	(4.8)	82	37.5	(5.5)
1970	121	16.0	(4.1)	78	41.2	(5.7)
1971 or later	68	3.6	(2.6)	51	32.4	(6.7)

record indicators is related to war zone stress in a consistent and predicable manner for males: those in the Army and Marine Corps report higher levels of war zone stress, as do those who received a combat medal and/or Purple Heart, those receiving a service-connected disability from the VA, and those beginning their Vietnam tour during the years of peak combat activity. Since each of these is less relevant to the situation of females serving in Vietnam, the lack of consistent relationships on these variables for women is not surprising.

Finally, Table D-7 shows the proportions of Vietnam theater veterans in each subpopulation who are classified as high or low on the primary and alternate war zone stress dichotomies. On either measure, white/other males serving in the Vietnam theater report significantly lower levels of exposure to war zone stress than either black or Hispanic males, while the latter do not differ significantly from each other. The distributions are presented for all female theater veterans because sample sizes do not allow for comparisons among racial/ethnic subgroups. In particular, since the war zone stress measures for males and females are based on almost entirely different component measures and different cutoff scores based on the weighted distributions within these two samples, comparisons between theater veteran men and women on their relative levels of exposure to war zone stress are clearly inappropriate.

Table D-7

Percent Distribution on Two Dichotomous Measures of War Zone Stress for Vietnam Theater Veterans, by Subgroup

Theater Veterans	Sample Size	War Zone Stressor Exposure Low-Moderate	War Zone Stressor Exposure High	War Zone Stressor Exposure (Alt.) Low-Moderate	War Zone Stressor Exposure (Alt.) High
1. Males					
a. White/Other	597	77.1 (1.9)	22.9 (1.9)	81.2 (1.7)	18.8 (1.7)
b. Black	312	62.6 (3.0)	37.4 (3.0)	69.6 (2.8)	30.4 (2.8)
c. Hispanic	280	67.3 (3.9)	32.7 (3.9)	71.4 (3.9)	28.6 (3.9)
2. Females	432	60.1 (2.4)	39.9 (2.4)	62.2 (2.4)	37.8 (2.4)

Contrasts	χ^2	df	p	χ^2	df	p
1a vs. 1b	16.55	1	.000	12.09	1	.001
1a vs. 1c	5.01	1	.025	5.31	1	.021
1b vs. 1c	0.90	1	.342	0.14	1	.721

Appendix E: Issues Related to the DIS Module for the Assessment of PTSD

I. Comparison of the Items Used in the CDC DIS PTSD Module With Those in the NVVRS DIS-Type Instrument

Exhibit E-1

COMPARISON OF SUBSTANTIVE CONTENT
OF NVVRS AND CDC PTSD MEASURES

Criteria	NVVRS	CDC
B - Intrusive	R81 Unpleasant memories	
	*R88 Bad dreams, nightmares	PT35 Bad dreams, nightmares
	*R120 Disturbing memories	PT35 Remember horrible things
	*R125 Flashbacks	PT35 Flashbacks
C - Numbing	*R64 Lost interest in activities	PT36 Lost interest in things
	R78 Felt numb, empty	
	R79 Stopped caring	
	R111 Felt cut off	
	*R112 Couldn't feel anymore	PT36 Less ability to care about others
D1 - Startle Response	*R65 Stay on guard	PT37 Put on guard
	*R80 Noises startle	PT37 Easily startled, jumpy
D2 - Sleeping	*R71 Difficulty falling asleep	PT38 Trouble sleeping
D3 - Guilt	*R106 Felt guilt	PT39 Ashamed being alive
D4 - Memory Problems	*R63 Trouble concentrating	PT40 Trouble concentrating
	*R100 Forget easily	PT40 Become forgetful
	R120 Can't remember certain things	
D5 - Avoidance	R66 Try not to think about traumas	
	*R94 Avoid places, activities remindful of traumas	PT41 Avoid activities remindful of traumas
	R101 Avoid feelings remindful of traumas	

Exhibit E-1 (Continued)

Criteria	NVVRS	CDC
D6 - Symptom Intensification	*R73 Spell - anxious	PT42 Situations remindful of trauma make symptoms worse
Associated Symptoms	R86 Felt out of control R113 Felt anxious R119 Little things bother	

* NVVRS items judged to best match CDC items and used in the NVVRS "best match" instrument.

II. Some Thoughts on Sensitivity Problems of DIS-Based Instruments

There are a number of reasons why the DIS or a DIS-type measure might tend to miss "true" cases of the disorder:

- The DIS uses complex sentences and phrasing which may make it difficult for the respondent to follow the question or to determine whether his or her problems are those being asked about in the items, particularly for respondents who may have difficulty concentrating on the questions because of the disturbing affect associated with them.

- The DIS tends to use only a few items to assess PTSD, not allowing for alternate ways of describing the symptoms to the respondent. In the DIS used by the CDC, nine questions are used to ascertain the presence of twelve symptoms (subcriteria). In some cases, two symptoms are asked about in one question, resulting in complex questions.

- To receive a diagnosis of PTSD, the DIS requires that the respondent have insight into the causal link between his problems and a specific traumatic event, even though the trauma may have occurred many years previously. Each question used to ascertain the presence of a symptom, e.g. trouble forgetting things or trouble concentrating, asks whether the respondent ever had that symptom "because of a horrible experience" or some similar phrase. To determine the recency of the symptom, the respondent is asked when was the last time he had the symptom when it resulted from the traumatic event.

Respondents, particularly those with delayed onset, may not be aware that irritability, a tendency to be easily startled, difficulties in getting to sleep, trouble concentrating, etc. may have resulted from a specific traumatic experience. They may not, therefore, be able to respond positively to questions which ask whether they ever (or in the last month) experienced this symptom as a result of a specific traumatic event. Asking a respondent whether currently he is easily startled as a result of a "firefight" with enemy forces which occurred twenty years ago may present serious difficulties for respondents and might result in underreporting of symptoms and decreased diagnostic sensitivity.

* Related to the preceding, in the DIS the respondent must be able to link specific symptoms to specific traumatic events in order to receive a diagnosis of PTSD. It is probably difficult for respondents who have experienced multiple combat traumatic events to determine which specific events resulted in which specific symptoms. For example, a respondent may have difficulty in answering when asked whether his trouble concentrating resulted from a specific fire fight, from witnessing the death of buddy who stepped on a land mine, or from being wounded by a fragmentation grenade. This would therefore tend to result in underreporting and so reduce diagnostic sensitivity.

* The DIS only codes symptoms related to the first two combat related traumatic events mentioned. Therefore, the diagnosis of PTSD is based on these two events. The NVVRS experience suggests that the most disturbing events (and, concomitantly, those with the most symptoms) often are not the ones mentioned first because of successful avoidance of the most painful memories.

- * The DIS requires that the respondent be able to call up the content of dreams and intrusive thoughts when asked by the interviewer, and that this content be about a specific traumatic event. However, successful avoidance and denial by PTSD victims means that this knowledge may often be out of focused awareness.

There are two additional reasons why the DIS might underestimate current prevalence:

- * Current prevalence estimates in the CDC study require that the respondent have symptoms from all required diagnostic criteria in the past month. However, clinical experience indicates that chronic PTSD is phasic in nature, that is, it waxes and wanes from month to month in relation to current stressors in much the way chronic medical conditions do. Periods dominated by symptoms of intrusion may alternate with periods dominated by symptoms of avoidance. Even though in the NVVRS a current clinical DSM-III-R diagnosis required that all diagnostic criteria be present in the past six months, some individuals working in this field would argue that a one year cut-off would be more in line with the phenomenology of those with chronic symptomatology. In fact, the CDC modified the standard DIS (Version IIIA) for their study. The standard DIS no longer requires that all criteria be recent for a current diagnosis.

- * Lower sensitivity for current disorder in the DIS may also result from the respondent being required to state not only that he is currently experiencing each symptom, but also that each symptom he is currently experiencing is the direct result of a traumatic event that occurred many years before. In fact, for many symptoms, such as forgetting things or being easily startled, there may be no way for the respondent to determine this.

REFERENCES

Card, J. (1983). Lives After Vietnam: The personal impact of military service. Lexington, Mass.: Lexington Books, 1983.

Card, J. (1987). Epidemiology of PTSD in a national cohort of Vietnam veterans. Journal of Clinical Psychology, 43, 6-17.

Cattell, R.B., & Vogelman, S. (1977). A comprehensive trial of the scree and KG criteria for determining the number of factors. Multivariate Behavioral Research, 12, 289-325

Centers for Disease Control Vietnam Experience Study. (1988). Health status of Vietnam veterans I. Psychosocial characteristics. Journal of the American Medical Association, 259, 2701-2707.

Egendorf, A. Kadushin, C., Laufer, R.S., Rothbart G., & Sloan, L. (1981). Legacies of Vietnam: Comparative readjustment of veterans and their peers. Washington D.C.: U.S. Government Printing Office.

Fischer, V., Boyle, J.M., Bucuvalas, M., & Schulman, M.A. (1980). Myths and Realities: A study of attitudes toward Vietnam era veterans. Washington, D.C.: U.S. Government Printing Office.

Helzer, J.E., Robins, L.N., & McEvoy, M.A. (1988). Post-Traumatic Stress Disorder in the general population: Findings of the Epidemiologic Catchment Area Survey. The New England Journal of Medicine, 317, 1630-1634.

Laufer, R.S., Gallops, M.S. & Frey-Wouters, E. (1984). War stress and trauma: The Vietnam veteran experience. Journal of Health and Social Behavior, 25, 65-85.

Mantell, D.M. & Pilisuk, M. (Eds.), (1975). Soldiers in and after Vietnam. Journal of Social Issues, 31.

Robins, L.N., Helzer, J.E., Croughan, J., Ratcliff, K.S. (1981). The NIMH Diagnostic Interview Schedule, Its History, Characteristics, and Validity. Archives of General Psychiatry, 38, 1381-389.

Rothbart, G.S., Fine, M., & Sudman, S. (1982). On finding and interviewing the needles in the haystack: The uses of multiplicity sampling. Public Opinion Quarterly, 46, 408-421.

Schindler F.E. (1980). Treatment by systematic desensitization of a recurring nightmare of a real life trauma. Journal of Behavior Therapy and Experimental Psychiatry, 2, 53-54.

Walker, Ingram. (1981). The psychological problems of Vietnam Veterans. Journal of the American Medical Association, 246,781-782.

Walker, J.I. & Cavenar, J.O. (1982). Vietnam veterans: Their problems continue. Journal of Nervous and Mental Disease, 170, 174-180.

Wilson, J.P,. (1978). Identity, Ideology and Crisis: The Vietnam Veteran In Transition, Vol. II. Washington, D.C.: Disabled American Veterans.

Wilson, J. (1980). Forgotten Warriors: America's Vietnam era veterans. Washington D.C.: Disabled American Veterans Association.

Yager, T., Laufer R. & Gallops M. (1984). Some problems associated with war experience in men of the Vietnam generation. Archives of General Psychiatry, 41, 327-333.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

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FOR RELEASE ONLY UPON DELIVERY

Testimony of

Vernon N. Houk, M.D.
Director, Center for Environmental Health and Injury Control
Centers for Disease Control
U.S. Public Health Service

DEPARTMENT OF HEALTH AND HUMAN SERVICES

before the

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

Thursday, July 14, 1988

9:30 a.m.

Room 628, Dirksen Senate Office Building

Good morning, Mr. Chairman. I am Dr. Vernon N. Houk, Director, Center for Environmental Health and Injury Control, Centers for Disease Control. I welcome this opportunity to appear before this Committee to describe the findings of the Vietnam Experience Study relative to post-traumatic stress disorder, or PTSD.

With me this morning is Dr. Robin Morris, Associate Professor of Psychology, Georgia State University, who has been a consultant to the Centers for Disease Control Vietnam Experience Study. First, I will summarize the findings of the Vietnam Experience Study on PTSD. Then I will address the specific issues you raised in your letter of invitation.

The Vietnam Experience Study PTSD Findings.

The Vietnam Experience Study was designed to evaluate possible health effects of the general Vietnam experience by comparing the physical and psychological health status of a cohort of male U.S. Army veterans who served in Vietnam with a cohort of male U.S. Army Vietnam-era veterans who served elsewhere. As you know, we presented the general design and findings of the study to your committee at the hearing of May 12, 1988.

Post-traumatic stress disorder was evaluated as part of the psychological evaluation of the subsample of veterans who participated in the examination component of the study. Post-traumatic stress disorder was assessed by using the Diagnostic Interview Schedule, or DIS. The DIS is a standardized questionnaire that is designed to assess the prevalence of certain psychiatric conditions according to criteria established by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders, Third Edition--the DSM-III. The DIS was administered by specially trained psychology technicians under the supervision of licensed clinical psychologists.

PTSD due to any cause was found to have occurred in 16.5% of Vietnam veterans and 3.2% of non-Vietnam veterans. Fourteen and seven tenths percent of Vietnam veterans had experienced combat-related PTSD at some time during or after military service. During the month before examination, or 15 to 20 years after service in Vietnam, 2.2% met the full diagnostic criteria for PTSD related to combat.

We also evaluated the onset, intensity, and duration of symptoms among the Vietnam veterans who had experienced combat-related PTSD. Nearly half reported developing symptoms the same day the traumatic event occurred, and 81% had developed symptoms within 6 months; only 4% reported developing symptoms more than 3 years after the event. About 60% indicated that PTSD symptoms had interfered with their life "a lot". Of the affected veterans, 31% had told a doctor about their problems related to PTSD symptoms and 6% had told another health professional. About one-fourth had taken medications more than once for symptoms related to PTSD.

Compared with Vietnam veterans who had not experienced the disorder or with non-Vietnam veterans, Vietnam veterans who had ever had combat-related PTSD were 2-3 times more likely to have alcohol abuse or dependence, 3-5 times more likely to have generalized anxiety, and 5-9 times more likely to have depression. These findings indicate that the elevated prevalence of anxiety, depression, and alcohol use disorders in Vietnam veterans compared with non-Vietnam veterans is concentrated in, but not exclusive to, Vietnam veterans who meet criteria for combat-related PTSD.

Vietnam veterans who had a tactical military occupational specialty, or MOS, low scores on military general technical examinations given at enlistment, a history of childhood behavior problems, or reported use of illicit drugs in the Army were more likely to have experienced combat-related PTSD than were veterans without these characteristics. The lifetime prevalence of combat-related PTSD was 20% among veterans who had a tactical MOS, which includes infantrymen, artillery men, armored vehicle crewmen, and combat engineers, compared with 12% among those with a nontactical MOS, which includes occupational specialties such as clerks and cooks as examples.

As part of the psychological evaluations, we also administered the Minnesota Multiphasic Personality Inventory, or MMPI. The MMPI is a self-administered questionnaire that provides a quantitative evaluation of personality, emotional status and level of psychopathology. There is no standard MMPI clinical scale for identifying persons with PTSD. There is a single research scale developed by Keane and associates, sometimes referred to as the

Mississippi scale, which has been shown to discriminate hospitalized patients with PTSD from other Veterans Administration patients. We found Vietnam veterans had higher mean scores on Keane's PTSD scale compared with non-Vietnam veterans. After excluding participants with unreliable responses, elevated scores on the PTSD scale were found in 0.8% of non-Vietnam veterans and 2.8% of Vietnam veterans, remarkably similar to the DIS results on current prevalence of combat related PTSD.

Responses to Specific Questions

Now I will address the specific issues you asked us to consider in your letter of invitation.

1. The Diagnostic Criteria Used in the Study and the Methodology of the Study.

   These were presented above in the summary of results. In our primary analyses, the diagnosis of PTSD was based on the DIS, which uses DSM-III criteria. We have attached a copy of the DSM-III criteria. In our study all four criteria had to be met for a diagnosis of PTSD. In addition to the DIS, we also evaluated the PTSD scale from the MMPI. These two questionnaires are the most widely used and best standardized assessment instruments available. They provide rigid criteria for the evaluation of PTSD.

2. How the Diagnostic Criteria the Centers for Disease Control Used Relates to the Veterans Administration Diagnosis of PTSD and to the Diagnostic Criteria Used by Research Triangle Institute in its Study of PTSD Among Vietnam-era Veterans.

It is our understanding that the Veterans Administration uses the 1987 revision of the DSM-III referred to as the DSM-III-R. The DSM-III-R criteria are generally similar to the DSM-III criteria which were in use in 1985 and 1986, the time of the Vietnam Experience Study. The major differences between the two versions are related to how some of the symptoms are described and categorized. The DSM-III-R provides more specific descriptions and examples of traumatic events and symptoms. The DSM-III-R also includes additional symptoms related to reexperiencing or recalling the traumatic event.

We have had discussions with researchers at Research Triangle Institute regarding their diagnostic criteria. It is our understanding that their study used their modification of the DIS and the MMPI in addition to a clinical psychiatric interview. We are not certain how their determination of PTSD compares with the criteria we used. We have not yet had an opportunity to review the results of their study. We have, however, provided RTI with the DIS questionnaire and diagnostic criteria we used in the Vietnam Experience Study so that the RTI researchers could analyze their data using criteria as similar as possible to those we used in the Vietnam Experience Study. We defer to RTI regarding specific details of those analyses and findings.

3. The Overall Significance of the Vietnam Experience Study Findings.

As we mentioned in our testimony of May 12, we feel it is significant that as recently as the month before examination 2.2% of the Vietnam veterans in our study had experienced a set of symptoms which meet DSM-III criteria for combat-related PTSD. Since the VES involved a random sample of Army enlisted veterans, these results apply to most Army enlisted veterans who served in Vietnam. These results indicate that a significant number of Vietnam veterans are still experiencing combat-related PTSD some 15 to 20 years after military service. These veterans with PTSD are also experiencing higher rates of anxiety, depression, and alcohol use disorders.

That concludes my testimony. I will be happy to answer any questions.

Attachment

ATTACHMENT

Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)
Diagnostic Criteria for Post-traumatic Stress Disorder
American Psychiatric Association

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:
1. recurrent and intrusive recollections of the event
2. recurrent dreams of the event
3. sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:
1. markedly diminished interest in one or more significant activities
2. feeling of detachment or estrangement from others
3. constricted affect

D. At least two of the following symptoms that were not present before the trauma:
1. hyperalertness or exaggerated startle response
2. sleep disturbance
3. guilt about surviving when others have not, or about behavior required for survival
4. memory impairment or trouble concentrating
5. avoidance of activities that arouse recollection of the traumatic event
6. intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

JUL 29 1988

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Mr. Chairman:

At the Veterans' Affairs Committee hearing on July 14, Dr. Vernon Houk was asked to submit for the record information on suicides in Vietnam veterans. We are enclosing information on our estimates of the numbers of suicides among Vietnam veterans and our assessment of the numbers that have appeared in the media ranging between 50,000 to over 100,000.

An identical letter is being sent to Senator Frank H. Murkowski.

Sincerely yours,

James O. Mason

James O. Mason, M.D., Dr.P.H.
Assistant Surgeon General
Director

Enclosure

SUICIDE AMONG VIETNAM VETERANS

The media have reported that suicides among Vietnam veterans range from 50,000 to over 100,000. In 1981, the figure of 50,000 was widely used. Then in 1986 and 1987, two books were published that suggested there were more than 60,000 suicides among Vietnam veterans. In October 1987, a lecturer in a history course on war appeared on a popular Sunday evening television program and stated that there were more than 100,000 suicides in Vietnam veterans. Mortality studies show that 9,000 is a better estimate.

Suicide among Vietnam veterans first emerged as a prominent national issue during the late 1970's. In October 1978, a Presidential Review Memorandum on Vietnam Era Veterans, which was provided to Congress, included the statement that Vietnam era veterans less than 34 years old had been found to have a suicide rate 23 percent higher than nonveterans. Subsequently, it was discovered that this reported excess of suicides was based on a study conducted in a Veterans Administration (VA) Hospital in which hospitalized Vietnam era veterans were compared with older hospitalized patients. In early 1979, in response to a congressional inquiry, the statement regarding excess suicides was retracted by the Administrator of Veterans Affairs. In a letter to the Chairman of the House Committee on Veterans' Affairs, the Administrator wrote "There are no published statistics on rates of suicide among nonhospitalized Vietnam era veterans and hence no precise statement can be made regarding such rates relative to those for the general population matched for sex and age."

Evidently, this commentary on the suicide data was not widely disseminated. A VA psychiatrist repeated the report of excess suicides with an article that appeared in the *Journal of the American Medical Association* in August 1981. The President's Memorandum also continued to receive attention in the popular press and in veterans' magazines but with a significant difference. The increased risk for suicides was described as occurring just among the approximately 2.6 million veterans of the Vietnam *war* rather than among the more than 8 million veterans who served during the Vietnam *era*. Furthermore, the increased risk was described as occurring among Vietnam veterans of all ages.

The CDC Vietnam Experience Study Mortality Assessment showed that during the first 5 years after discharge deaths from suicide were 1.7 times more likely among Vietnam veterans than non-Vietnam veterans. After that initial postservice period, Vietnam veterans were no more likely to die from suicide than non-Vietnam veterans. In fact, after the 5-year postservice period, the rate of suicides is *less* in the Vietnam veterans group.

Of the several mortality studies of Vietnam veterans, only the CDC study and the Wisconsin Department of Health Vietnam Veterans Study provide suicide rates necessary to estimate the number of suicides among all Vietnam veterans. Using either study, the projected number is approximately 9,000 (95% CI=6,500-13,000) suicides expected among the 2.6 million veterans of the vietnam war.

The proportion of deaths due to suicide in CDC's investigation (13%) is comparable with the proportions found in four State mortality studies (9%-16%)--Wisconsin, Massachusetts, New York, and West Virginia.

At any time during the Vietnam War, 37 million males in the United States were aged 18 through 35. Vital statistics show that the total number of suicides in this population of 37 million males through 1985 was slightly under 152,000. Of these 37 million males, 2.6 million served in Vietnam. If the reports in the press of up to 100,000 suicides were accurate, this would indicate that two-thirds of all the suicides that occurred in this population of 37 million men came from the 2.6 million who served in Vietnam. This is not supported by any factual information.

We have submitted to the committee a CDC presentation which was made at the 1988 meeting of the Society for Epidemiologic Research, June 15-17, 1988, in Vancouver, British Columbia, Canada, which was entitled "Estimating the Number of Suicides Among Vietnam Veterans."

STATEMENT OF ROGER HAMADA, PH.D.
CLINICAL PSYCHOLOGIST AND RESEARCH ASSOCIATE
VETERANS' ADMINISTRATION OUTPATIENT CLINIC
HONOLULU, HI

Mr. Chairman and Distinguished Members of the Committee:

Thank you for inviting me to contribute to this auspicious and important hearing. My name is Roger Hamada. I am a Clinical Psychologist and a Research Associate affiliated with the Stress Disorders Research Laboratory of the Veterans Administration Outpatient Clinic in Honolulu, Hawaii which is directed by Dr. Claude Chemtob. I am here today to describe and share with you our observations and research on combat-related PTSD among Asian-American and Pacific-Islander Vietnam veterans, specifically, and to argue generally that it is critical to enhance cultural sensitivity within the VA as regards the identification, understanding, treatment, and prevention of the deleterious impact of combat on veterans of ethnic minorities.

Asian-American and Pacific-Islander peoples have a proud tradition of service to their country. The loyalty and sacrifices of the 442nd Combat Regiment and the 100th Battalion Combat Team during the Second World War, which were comprised primarily of Asian-Americans and of which the Honorable Senators Matsunaga and Inouye were distinguished members, are well recognized. Asian/Pacific-Islander American veterans also served the United States well in Korea and in Vietnam. Fully 85,148 of the American men and women who served in the Armed Forces during the Vietnam era were Asian/Pacific-Islander Americans (1980 census). Nineteen thousand two hundred six of these 85,148 Asian/Pacific-Islander American Vietnam and Vietnam-era veterans live in Hawaii, a number second only to the 33,817 who live in California. Asian and Pacific-Islander American veterans comprise 69% of the veteran population in Hawaii. However, clinicians in

Hawaii who treat veterans with PTSD report that Asian and Pacific-Islander Americans are markedly underrepresented among the veterans seeking their help. This clinical impression of low utilization of VA-affiliated mental health services by these veterans is supported by Vietnam Vet Center Program National Statistics for the six-month period October, 1983 to March 1984 which show that only 0.5% (380 out of 75,169) of the veterans served by Vet Centers of this period were of Asian ancestry.

Given this impression of low utilization of services by Asian/Pacific-Islander American Vietnam veterans, some obvious questions immediately arise. Is the impression, in fact, correct? That is, do Asian/Pacific-Islander Vietnam veterans underutilize mental health services? If they do underutilize services, is it because proportionately fewer Asian/Pacific-Islander veterans suffer combat-related post-traumatic stress symptoms, and hence fewer Asian/ Pacific-Islander veterans require these services? Are these veterans in some sense "invulnerable" to the stresses of combat which have affected veterans of other ethnic groups? Or are there some other explanations for this underutilization of services?

Unfortunately, to our knowledge, data which might provide direct answers to these questions are lacking. VA service utilization statistics which are broken down by ethnic identification of the utilizer are, to our knowledge, either unavailable or do not provide a category for Asian/ Pacific-Islander veterans. In major epidemiological studies of the prevalence of mental disorder in the general population and among Vietnam veterans specifically (the Epidemiologic Catchment Area Program and the National Vietnam Veterans Readjustment Study) which have included large samples of and over-sampled Blacks and Hispanics for the purpose of addressing ethnicity as a factor in the prevalence of mental disorder, Asian/Pacific-Islander Americans were sampled in such small numbers that meaningful analyses of data relevant to this group were not possible. In other words, meaningful and representative data on the prevalence of combat-related disturbance among veterans of Asian/Pacific-Islander ethnicity are sadly lacking.

One might argue that it is not necessary to collect such data since the apparent underutilization of services by Asian/Pacific-Islander American veterans reflects the relative absence of disorder and the comparative mental health of this group. Written first-person accounts by Asian American veterans as well as the accounts of Asian/Pacific-Islander veterans interviewed in the course of experimental research on PTSD by our research team at the Honolulu VAOPC, strongly contradict this contention. In fact, Asian/Pacific-Islander veterans seem to have suffered Vietnam-related stresses unique to them, in addition to the traumas of combat generally experienced by veterans of all ethnicities.

For example, as we and others have reported elsewhere, some Asian American Vietnam veterans reported considerable distress at being Asian in a war against Asians. Reactions ranged from the somewhat mild recognition that the Vietnamese looked more like the Asian-American veterans than did their fellow soldiers, to the intense guilt and trauma associated with comparing Vietnamese women and children who were being killed with one's own mother and siblings. The young Asian-American soldiers in Vietnam also suffered cultural conflict. They generally had assimilated Western culture to the extent that they considered themselves to be full-fledged Americans. These individuals were often shocked, therefore, to encounter both overt and subtle racism from American Anglo soldiers who pointed to their Asian brethren as being "gooks," asked them if they understood English, and shot at them when mistaking them for Vietnamese. Compounding the problem, some Asian-American soldiers felt renewed ties to their Asian heritage through their observations of Vietnamese culture so that they experienced acute and distressing ethnocultural ambivalence and conflict.

Asian-American veterans faced the same welcome on their return home as did other veterans; a welcome which was lukewarm at best, and sometimes hostile. In addition, Asian-American veterans faced strong cultural sanctions against talking about their combat experiences or any emotional or psychological distress they might be experiencing as a result of war-time stress. This sanction was particularly strong within their immediate families where implicit, nonverbal communication was stressed, and where for a man to express weakness or mental suffering would bring shame on the man and on recipient of the communication. In this family context, social support which might have been available to other veterans was unavailable to the Asian-American veteran.

One additional Vietnam-related post-war stressor which we have not heard from Hawaii veterans, but which Dr. Cole Lew, formerly of the San Francisco Vet Center, has recounted, involved his clients' experiences on the Mainland United States being scorned and being called "gooks" by fellow veterans when the Asian-American veterans came to Vet Centers for assistance or when they visited the replica of the Vietnam Memorial Wall. In short, clinical impressions indicate that cultural and ethnic factors appear to have made both inservice experience and the seeking of help post-service more difficult for some Asian-Americans.

A growing body of research on the influence of cultural factors on psychopathology and on the utilization of mental health services among ethnic minorities in the general population strongly suggests that disproportionately low utilization of services by non-veteran Asian-Americans does not necessarily reflect a low rate of psychopathology. Data based on utilization records of mental health clinics and hospitals and from community and university mental health clinics indicate a lower rate of service utilization by Asian-Americans than would be expected based on their representation in the community population. Moreover, those Asian-Americans who do seek treatment tend to be more severely disturbed than non-Asians, suggesting that Asian-Americans seek formal mental health treatment only when disorders are relatively severe. A culturally sensitive interpretation of these data would take into account such issues as Asian-Americans' very strong cultural prohibitions against the admission of personal problems which they see as reflecting shame and stigma on the individual and the entire family, and their tendency to view mental illness as associated with organic or somatic factors, while mental health involves the avoidance of morbid thoughts.

In summary, clinical evidence is available to support an argument that Asian/Pacific-Islander veterans are not "invulnerable" to the stresses of combat, and have, in fact, experienced Vietnam-related stresses unique to their ethnicities over and above those experienced by other combat veterans. However, it is glaringly clear that systematically-collected, objective, representative data are needed which can directly address this issue. Such data could be obtained in a comprehensive and methodologically sound epidemiological study of PTSD among Asian/Pacific-Islander veterans such as that called for by Senator Matsunage in S. 2521. It is critical that cultural factors be considered in carrying out such a study. For example, cultural factors may influence the clinical presentation of PTSD and, therefore, distort the identification of cases and the prevalence estimates of post-traumatic symptoms. In addition, cultural and familial sanctions against discussing personal problems or symptoms of "mental illness" may compound the feelings of distrust and alienation generally experienced by many Vietnam veterans and may make it difficult to obtain representative samples of veterans. Successful completion of such a study would not only contribute significantly to understanding PTSD among Asian/Pacific-Islander American Vietnam veterans and to ensure their receipt of appropriate services, but would also stand as a landmark accomplishment in cross-cultural research.

As argued above, awareness of and sensitivity to cultural factors are critical in epidemiological research and other kinds of research on PTSD. Cultural sensitivity is just as critical in the identification of PTSD-related symptoms, in the treatment of PTSD, and in the prevention of this disorder. In the area of treatment, for example, it is well established that larger proportions of ethnic minority clients than majority clients drop out of treatment prematurely, often after their first session. Reasons for this premature termination are varied, but many are culture-related. For example, discrepancies between views of mental illness held by counselors and clients may discourage ethnic clients from remaining in treatment. Counselor expectations for client behavior in therapy may also differ from how an ethnic client expects to behave. Asian-Americans feel stigma and shame in talking about personal problems and may be perceived by counselors as "repressed," lacking in psychological-mindedness and insight, and unwilling to discuss intimate details of their lives. In group therapy, which is one of the preferred therapy modes for treating PTSD, strong Asian-American values of politeness and deference to authority figures may result in their being perceived as unassertive, passive, and unwilling to participate in the group. Asian and Pacific-Islander combat veterans who have dropped out of therapy Rap Groups have told us that they terminated treatment because they were never given a chance to talk. When asked why they did not participate more actively, veterans have said, "The other guys seemed to need to talk more than I did," and, "If what the other guys were saying wasn't important, the counselor would have interrupted them, but I couldn't interrupt."

An argument for cultural sensitivity in the treatment of PTSD does not imply that therapists and clients must be of similar ethnicity. Rather, treatments must be implemented with the cultural nuances of the client in mind. In areas with relatively high proportions of ethnic veterans, treatment provided should be bicultural and, where appropriate, bilingual. Efforts such as the VA Neighborhood Clinic in East Los Angeles which provides bilingual and bicultural services to a predominantly Mexican-American community should be encouraged, supported, and evaluated. Potential clients should be given some freedom of choice with respect to the ethnicity of professionals with whom they work. Case finding and outreach must be planned and carried out with full consideration of how cultural factors affect information, power, and social networks in the ethnic community.

In summary, the meaning of serving one's country is interpreted through these cultural lenses as is the development of PTSD symptoms. Individuals carried their ethnicities and cultures into combat with them and returned from combat also bearing those ethnicities and cultures. It is crucial that ethnic and cultural factors be recognized as significant influences on how those individuals manifested the effects of combat-related stress and coped or failed to cope with that stress. Culturally sensitive research and treatment of Black and Hispanic veterans is already evident within the Veterans Administration. Mr. Chairman, members of the Committee, I respectfully ask you to ensure that the unique problems and needs of the Asian/Pacific-Islander Vietnam veterans receive similar formal attention and recognition.

Thank you for your kind attention and for the opportunity to present this testimony.

Honolulu, HI 96850

Veterans
Administration

July 28, 1988

In Reply Refer To:

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Senator Cranston:

This is in response to your letter dated July 21, 1988 in which you requested information and results of our research concerning PTSD as it relates to Asian-American and Pacific-Islander veterans.

The research we are undertaking at the Stress Disorders Research Laboratory of the Honolulu, VA Outpatient Clinic is funded by the VA through a Merit Review Award to Dr. Claude M. Chemtob, who is its Principal Investigator. The project is entitled "Cognitive Dysfunction in Post Traumatic Stress Disorder Patients" and is a multi-part, three-year (1987 to 1990) program of research. The project is designed to test one facet of a cognitive model of PTSD developed by Dr. Chemtob in collaboration with Drs. Roitblat, Hamada, Carlson, and Twentyman (in press). I function as project director. Please note, this research was not designed specifically to study the relationship between ethnicity and PTSD. However, because of the unique makeup of the veteran population in Hawaii, a number of Asian/Pacific Islander veterans have participated, and will participate, in this research.

Our program of research comprises an interdependent series of three studies on attention and information processing in veterans with PTSD, an ancillary study on anger in veterans with PTSD, and a study of Special Forces veterans. Data collection for the study on anger is complete and the data are currently being analyzed. Data for the series of three interrelated studies are currently being collected.

The methodology for this research is complex, varied, and may not be relevant to your concerns. I have enclosed an abstract of the methodology for the overall program. Let me take this opportunity to expand on the one aspect of the research which probably is most relevant to your interests. This has to do with our subject selection process. We have solicited the participation of Vietnam combat veterans through a mass mailing based on information in the VAOPC medical database, through a newspaper article, and through counselors from the local Vet Center, VAOPC Mental Health Clinic, and from the psychiatric unit of Tripler Army Medical Center. Those veterans who respond and are willing to participate in the research undergo the following diagnostic process:

"America is #1—Thanks to our Veterans"

1. They are administered the Structured Clinical Interview for DSM-III-R (non-patient version) (SCID-NP; Spitzer, Janet, and Gibbon, 1987). This interview is a comprehensive and detailed psychiatric diagnostic interview developed by the same people who oversaw the latest revision of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (1987). The interview is carried out in an individualized, face-to-face meeting between the veteran and a trained interviewer. The interview ranges from being 1-1/2 to 3 hours long. Veterans also complete the Mississippi Scale for Combat-Related PTSD (Keane, Caddell, and Taylor, in press) and the PTSD subscale of the MMPI (Keane, Malloy, and Fairbank, 1984). These three instruments were also used in the National Vietnam Veterans Readjustment Survey as part of their clinical prevalence of PTSD assessment. Those veterans for whom a diagnosis (or absence of disorder) is not clearly established, or for whom SCID, PTSD subscale, and Mississippi scale scores are discrepant, are discussed in a consensus conference between the interviewer and two clinicians who have extensive experience diagnosing, treating, and studying PTSD. The data are reviewed and discussed until some consensus is reached regarding the veteran's diagnosis. Using this diagnostic process, we can determine which veterans have current PTSD and/or other disorders, and which veterans are currently well-adjusted. Based on these diagnoses, veterans are assigned to experimental groups and participate in the other stages of research, or they are screened out of the project.

To date, 69 Vietnam combat veterans have gone through this diagnostic process, and we are continuing to interview veterans. Although data from the later phases of the research are not yet available, the diagnostic data obtained thus far are available and will be summarized below.

Eighteen veterans (26%) are Asian/Pacific Islanders. Of these, 2 (11%) have current PTSD alone, while an additional 3 (17%) have current PTSD concurrent with another psychiatric disorder (i.e., alcohol or other psychoactive substance dependence/abuse, major depression, other mood disorder, other anxiety disorder). Six (33%) of these veterans have sub-threshold PTSD; that is, they have symptoms of PTSD which are not severe enough or do not meet criteria for the full clinical syndrome. Hence, 11 (61%) of these Asian/Pacific Islander veterans are affected in some way by PTSD symptoms. Only 4 (22%) of these veterans we have seen have no current psychopathology.

Of the 51 White veterans interviewed thus far, 6 (12%) have current PTSD, 10 (20%) have PTSD with another concurrent disorder, and 5 (10%) have subthreshold PTSD. Hence, 21 White veterans (42%) are affected by PTSD symptoms, while 23 (45%) have no detected symptoms of any current psychopathology.

. . .

Based on these data, derived from research which is currently in progress, 61% of Asian/Pacific Islander Vietnam combat veterans are affected to some degree by symptoms of PTSD. This figure contrasts with the 42% derived for White veterans.

We hasten to point out that these results must be interpreted with caution. First, our research is not epidemiological. We do not have the objective of estimating a prevalence rate for PTSD among Hawaii veterans. Therefore, our methodology was not designed to obtain representative community sampling of Vietnam veterans. For example, our research participants are volunteers and are, therefore, self-selected. Furthermore, most, if not all, the research participants were solicited from VA records, so that those veterans who have sought mental and/or physical health services from the VA were primary candidates for the study. We strongly suspect that ethnicity is significantly associated with utilization of VA services such that White veterans comprise a disproportionate segment of the patient population, given their representation in the community. In this study, so far, only 26% of participants are Asian/Pacific Islanders, although over 60% of veterans in Hawaii are from this ethnic category.

Second, our research was not designed specifically to investigate ethnicity as a factor in PTSD. We have not made specific provisions for cross-cultural considerations in this project. It may be, for example, that ethnocultural factors affect the clinical presentation of PTSD so that the SCID, which is based on a Western model of psychopathology, is not sufficiently sensitive to detect clinically significant PTSD in non-White veterans. Any prevalence study of non-White veterans must consider issues of the cross-cultural validity of diagnostic instruments. Experts in the area of cross-cultural psychopathology, such as those on the faculty of the University of Hawaii, must be consulted in designing such a prevalence study.

Third, our research is in its early stages, and the data are far from being completely collected or analyzed.

Senator Cranston, I would like to reiterate the plea I made in my testimony to the Senate Committee on Veterans' Affairs. We appeal for increased cultural sensitivity in the VA in its research on, outreach to, and treatment of ethnic minority Vietnam veterans, and for a study specifically designed to determine prevalence of PTSD among Asian/Pacific Islander Vietnam veterans. We believe it critical that the VA undertake to achieve these objectives in order to ensure full and equal consideration of all veterans' needs, regardless of their ethnicity. We, in Hawaii, are prepared to assist in any way we can.

. . .

Thank you for inviting me to appear before your committee and for this opportunity to provide more details of our research. Please contact me or Dr. Chemtob if you require additional information.

With highest regards,

ROGER S. HAMADA, Ph.D.
Research Associate

Enclosure

cc: Honorable Frank H. Murkowski
Honorable Spark M. Matsunaga

REFERENCES

Chemtob, C. M., Roitblat, H. R., Hamada, R. S., Carlson, J. G., and Twentyman, C. T. (in press). A cognitive action theory of post-traumatic stress disorder. Journal of Anxiety Disorders.

Keane, T. M., Caddell, J. M., and Taylor, K. L. (in press). The Mississippi scale for combat-related PTSD. Journal of Consulting and Clinical Psychology.

Keane, T. M., Malloy, P. F., and Fairbank, J. A. (1984). Empirical development of an MMPI subscale for the assessment of combat-related PTSD. Journal of Consulting and Clinical Psychology, 52, 888-891.

Spitzer, R. L., Williams, J. B. W., and Gibbon, M. Structured clinical interview for DSM-III-R-Non-patient version (SCID-NP 4/1/87). Biometrics Research Department, New York State Psychiatric Institute, 722 West 168th Street, New York, NY.

PRINCIPAL INVESTIGATOR	LOCATION OF MEDICAL CENTER/CLINIC
Claude M. Chemtob, Ph.D.	OPC, Honolulu, Hawaii

TITLE OF PROGRAM/PROJECT (Not to exceed 72 typewriter spaces)

Cognitive Dysfunction in Post Traumatic Stress Disorder Patients

BRIEF STATEMENT OF RESEARCH OBJECTIVES (Do not use continuation sheets)

DSM-III highlights a number of PTSD symptoms that are primarily cognitive, including intrusive flashbacks, inhibitory processes such as "numbing" of affect, difficulty concentrating, and hyperalertness. Despite the apparent centrality of cognitive components in PTSD, few studies have directly investigated the cognitive functioning of patients with combat-related PTSD. This is significant because research on cognition in these patients would provide important clinical information and add substantially to what we know about the effects of stress and arousal.

We propose a cognitive model of PTSD that can account for the major symptoms of the disorder by asserting that, compared to normal individuals, those with PTSD show a greater focusing of attention on trauma-related stimuli. This focusing of attention leads to exacerbation of threat arousal which leads, in turn, to further focusing of attention and to inhibition of alternative cognitive schema or modes. As a result, the person experiences difficulty attending to other sources of information. We propose to test this model and validate it on Vietnam veterans.

Experiment 1 develops a library of picture and word stimuli that are either Vietnam combat related or neutral. We will validate these items using veterans with PTSD, combat and Vietnam era veterans without psychiatric or psychological disorders and on another control group with Vietnam-era patients with psychiatric disorders. Extensive multimethod assessment procedures including structured interviews, and psychophysiological information are used to diagnose potential subjects. We will collect physiological and behavioral measures from individuals who meet our diagnostic criteria and use these measures to corroborate self-report ratings of the stimuli. Finally, the stimuli will be rated for memorability and checked by having subjects recall them. This experiment will provide a library of stimuli to be used in subsequent experiments, both by ourselves and others.

Experiment 2 uses the picture stimuli validated in Experiment 1 to study the degree to which Vietnam related scenes compel attention and act as distractors interfering with other tasks. We will have subjects search for digit targets accompanied by distractors that are neutral (North American scenes) or threat related (Vietnam scenes). We will concurrently measure psychophysiological arousal. This tests the hypothesis that PTSD patients have a precurrent bias to attend to threat-related information at the expense of attention to other information.

Experiment 3 is designed to determine whether the drop in efficiency in detecting neutral targets accompanied by threat distractors is due to a general loss of information-processing efficiency or is due to specific interference from processing the threat stimuli at the expense of the target detection task. We will also be able to determine whether individuals with PTSD show high gain in arousal to all kinds of stimuli or are restricted to showing high gain in response to threat-related stimuli.

This research, in addition to testing the proposed model of cognitive dysfunction in PTSD, is designed to provide a conceptual foundation for the treatment of PTSD by establishing a beneficial link between basic research in cognitive psychology and PTSD research. This should support the development of specific cognitive and behavioral techniques aimed at treating PTSD.

7/87

United States General Accounting Office

GAO

Testimony

For Release
on Delivery
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July 14, 1988

Changes in the Delivery of Selected Mental Health Services at Veterans Administration Medical Centers

Statement of
David P. Baine, Associate Director
Human Resources Division

Before the
Committee on Veterans' Affairs
United States Senate

GAO/T-HRD-88-22

SUMMARY

In 1985, the Veterans Administration (VA) implemented a new resource allocation methodology that is designed to encourage increased productivity and efficiency at its medical centers. Through a survey of 14 medical centers, GAO found that, in response to the methodology's incentives, changes were being made in the treatment programs for veterans with post-traumatic stress disorders, alcohol and drug dependencies, and other long-term psychiatric conditions.

Most of the changes GAO identified were rewarded under the methodology. However, some changes, primarily those aimed at shortening the lengths of stay in programs treating post-traumatic stress disorders, penalized, rather than rewarded, the centers' programs. VA is currently analyzing how the methodology relates to psychiatric programs.

According to VA officials, some service delivery changes made in response to the methodology were viewed as beneficial to veterans because they increased access to care, while others were perceived less favorably because they limited the care provided. However, VA has not conducted local or national clinical evaluations to determine the effects of the changes on the quality of care delivered to veterans.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the preliminary results of our work at several Veterans Administration (VA) medical centers on inpatient programs providing treatment of veterans with post-traumatic stress disorders (PTSD), alcohol and drug dependencies, and other long-term psychiatric disorders. As you know, in fiscal year 1985, VA introduced a new budget allocation system called the resource allocation methodology, which is intended to encourage increased productivity and efficiency at its medical centers. We visited 3 medical centers to identify changes they made in the three programs in response to the new methodology and phoned officials at 11 other centers to discuss whether they had also made changes.

Medical center officials had made changes in one or more of the programs at the centers we contacted, and these officials said that most of the changes were made in response to the incentives VA had incorporated into the methodology. Several types of changes resulted in the programs' benefiting under the methodology. However, when centers attempted to reduce their lengths of stay in some programs, primarily PTSD, these programs were, in effect, penalized rather than rewarded. We believe this occurred because the current methodology is not adequate to measure productivity increases for programs like PTSD, which require long patient stays. VA is currently analyzing how the methodology relates to psychiatric programs.

Medical center officials provided us their views concerning how the changes made in the programs affected the care provided to veterans. However, VA has not conducted local or national clinical evaluations to determine the effects of the changes on the quality of care provided to the veterans served.

CHANGES REWARDED UNDER THE METHODOLOGY

I would first like to highlight five types of changes at the 14 medical centers that were rewarded under the methodology.

Length of Stay

Under the methodology, workload is measured through the use of diagnosis related groups (DRGs)--a method used to classify patients with similar diagnoses and other characteristics. Patients in each group generally are expected to have comparable costs of treatment based on similar lengths of stay. A basic credit is earned for each patient discharged under each DRG regardless of the patient's length of stay, up to a specified limit. For example, in fiscal year 1986 an alcohol treatment program earned $1,550 for certain discharges within a 40-day limit; PTSD programs earned $1,772 for each patient discharged within a 45-day limit. As long as patient stays already are below the limit, programs would benefit if they were able to discharge patients more rapidly and thereby treat additional patients within existing staffing and other resource constraints.

Two medical centers we visited, as well as five contacted by phone, earned additional workload credits because they reduced lengths of stay. For example, one alcohol and drug treatment program we visited earned $1,550 in 4 weeks rather than 5 by reducing the predefined length of stay 1 week. According to program officials, the shortened length of stay was expected to have varying effects on veterans depending on their conditions. However, they argued that the change would provide greater access to care by allowing more veterans to be served each year.

At a second center we visited, the predefined length of stay was reduced from 4 to 2 weeks for an alcohol treatment program. This allowed the program to earn $3,110 from serving two patients in the same time period that it had previously needed to earn $1,550 from serving one. However, shortening the program's length of stay led to a change in the patient population served, according to program officials. Before the change, the program served patients with alcohol dependence problems that were exacerbated by the presence of other medical and psychological problems. Because officials felt that these patients could not be treated in the 2-week period, new admissions to the program were restricted to patients with fewer complicating problems.

New Program Components

Two medical centers we visited, as well as three contacted by phone, added new program components, which allowed them to earn additional credits. Officials told us that these changes were made to improve service delivery to veterans.

For example, one medical center we visited and two we contacted by phone implemented new assessment programs for PTSD patients without additional costs because the programs were implemented with existing staff. The assessment programs, which were designed for patients to have a 3-day length of stay, earned $1,772 for each patient diagnosed to have PTSD. Before this change, the program received no credit for patients' assessments because they were performed elsewhere. According to VA officials at the center we visited, the new 3-day program was developed to provide a more comprehensive assessment of patients seeking treatment than was done previously. Also, it allowed the veterans to make more informed decisions about whether they wished to participate in the center's regular treatment program.

One alcohol treatment program we visited introduced a new program component that allowed discharged patients to return for a 3-day stay to reinforce the results of prior treatment efforts. The program earned a credit of $1,550 for each 3-day stay.

Improved Bed Utilization

Officials at one medical center we visited improved its bed utilization by shifting beds from general psychiatry to the PTSD program in response to the methodology's financial incentives. The beds would have remained idle for an extended time in the psychiatry unit because of difficulties in hiring nurses and other medical staff. According to VA officials, the PTSD program was operating at full capacity, and its existing staffing level was sufficient to cover the additional beds. Thus, new patients were treated for whom workload credits were earned that would otherwise not have been earned.

Administrative Changes

Two medical centers we visited made administrative changes, which program officials told us they made to improve the accuracy of the data being reported. For example, one center reevaluated the diagnoses of patients discharged from its 3-day assessment program. It decided that another psychiatric diagnosis was more clinically appropriate than PTSD for at least 60 percent of the patients. By changing these patients' diagnoses, the program earned additional credit because the basic credit for each discharge with the other diagnosis is $2,436 while the basic credit for each discharge with a PTSD diagnosis is $1,772. While this change increased the program's earned credits, it was not expected to affect the veterans served.

Staffing Changes

One of the ways that programs can achieve the methodology's objectives to increase efficiency is to reduce costs. Staffing costs accounted for more than 90 percent of the direct costs for treating psychiatry patients at the medical centers we visited. Staff reductions, therefore, represent the primary means for a program's costs to be reduced.

Officials at two centers we visited and six contacted by phone told us that staffing levels were reduced. In two PTSD programs we visited, for example, staffing levels were reduced about 15 percent--3.5 full-time employee equivalents in one program and 4 in the other. Program officials reported that all of the staff reductions, which involved social workers, nurses, and other direct care providers, were accomplished through attrition or transfers to other sections of the medical centers. They also reported that the reductions were generally expected to reduce the care provided to veterans but that the care provided would remain at acceptable levels of quality.

CHANGES THAT PENALIZED PROGRAMS

Changes made to shorten lengths of stay penalize certain programs. Programs earn the same credit for each patient discharged within a DRG's established length of stay limit. However, for discharged patients with lengths of stay beyond the established limit for a DRG, programs earn a basic credit for the

DRG plus additional credits equivalent to $90 a day for each day of care over the established limit.

At the facilities we visited, three PTSD programs, one alcohol and drug program, and one long-term psychiatry program reduced their lengths of stay and received lower, rather than higher, credits under the methodology. We believe that this occurred primarily because the treatment in these five programs always took much longer than the length of stay limit established for the DRG covering such patients. The following example illustrates this situation.

A PTSD program we visited reduced its predefined length of stay from 120 to 90 days. Before the change the program earned $8,522 for a 120-day stay. After the 30-day reduction, the program earned $5,822 for each patient discharged--a $2,700 loss. The change gained the facility 30 days during which new patients were treated. However, the program earned only $1,772 for the first 45 days of each new patient's stay.

We found that similar results occurred in 7 of the 11 PTSD programs and 4 of the 9 long-term psychiatry programs at the centers we phoned. Officials at all but one of the centers told us that these changes were made in response to the introduction of the resource allocation methodology even though our analysis suggests they reduced the aggregate credit the programs could earn.

RECENT REFINEMENTS IN THE METHODOLOGY

Mr. Chairman, it is important to note that VA's Department of Medicine and Surgery continues to analyze the methodology as it relates to psychiatry. In 1984 VA began a project to identify more clinically meaningful psychiatric DRGs. The results of this analysis are being reviewed by VA officials and outside experts.

Also, VA has recently changed the implementation of the methodology to recategorize its medical centers into six groups of similar sizes and types of facilities. One of the groups contains medical centers designated primarily as psychiatric facilities. This change--which will affect budget allocations for fiscal year 1989--is intended to enable medical centers to compete for budget resources under the methodology with similar facilities rather than with all medical centers in the system. It is not yet clear whether this regrouping of facilities will help to alleviate the impact of the penalties that some programs incur when they reduce lengths of stay.

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This completes my prepared statement, Mr. Chairman. My colleagues and I would be pleased to respond to your questions.

Testimoney on S.2462

Veterans Administration Health Care Personnel and Programs Act of 1988

Prepared Statement to the United States Senate Committee
on Veteran's Affairs

by

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In December 1984, the Chief Medical Director (CMD) of the Veterans Administration (VA), in accordance with Public Law 98-528, established a Special Committee on Post-Traumatic Stress Disorder (PTSD). This committee, called the CMD's Special Committee on PTSD, is mandated to assess the capacity of the Veterans Administration to provide diagnostic and treatment services to veterans of all wars eligible for health care furnished by the VA. The Special Committee is also charged to advise the CMD regarding the development of policies, provision of guidance and the coordination of services for the diagnosis and treatment of PTSD. Congressional concern with the adequacy of VA efforts in this area is manifested in the mandate of the Special Committee to consider the capacity, ability, and resource commitment of the VA to the treatment of PTSD and to report annually to Congress through 1989.

It is a major challenge to the Veterans Administration to meet the needs of the psychological casualties of war. The responsibility of the VA to provide leadership in this area is abundantly clear from the fact that the care and treatment of combat veterans was the original purpose for the nation's establishment of the Veterans Administration. The Special Committee believes that allocation of FTEE and dollars to this end should not only be tied to availibilty of resources, but also to the priorities of the VA. One cannot overemphasize the fact that PTSD among combat veterans is a war-related disability and therefore should be one of the top priorities for this health care system.

Post-Traumatic Stress Disorder

Throughout history there have been many names applied to what we now call PTSD. Shell shock, traumatic neurosis, soldiers' heart, and battle fatigue are but a few of the terms that have been applied to this condition. The problems combat veterans experience may begin immediately after the combat experience or be delayed for many years. PTSD can become a chronic disabling illness in which the veteran is vulnerable to relapse throughout his or her life. Symptoms are often exacerbated later in civilian life by severe life stresses such as death, retirement, unemployment, divorce, or serious impairment of health. There is no doubt that PTSD is directly related to the severity and duration of combat exposure or the life threatening experiences of prisoners of war who have been captured, imprisoned, deprived and psychologically threatened.

Explicit diagnostic criteria were set forth for Post-Traumatic Stress Disorder in the third edition of the Diagnostic and Statistical Manual (DSM-III) of the American Psychiatric Association. The symptoms of PTSD include intense reliving of the traumatic event either through intrusive day dreams or recurrent nightmares of the traumatic event, intensification of symptoms on exposure to meaningful stimuli reminiscent of the event, exaggerated startle responses, hyperalertness, anxiety, hypervigilance, sleep disturbance, guilt about surviving when others have not, depression, memory impairment, difficulty concentrating, avoidance of reminders of the traumatic event, and a variety of psychosomatic symptoms, social isolation and incapacity for intimate relations with others. In some patients with this disorder, anxiety and depessive symptomatology may dominate the clinical picture.

The severity of this disorder varies from relatively mild to extremely severe. In some cases, the impairment is pervasive and affects all areas of the patient's existence. The veteran patient with PTSD may spend his entire post combat life in a constant state of upheaval plagued by intrusive recollections and feelings related to his combat experience that are triggered by cues in the civilian environment. He/she may react to these cues with fright or anger as if he/she were back in the war zone. A constant level of vigilance, and anxiety is frequently experienced resulting in marked interpersonal problems both at work and in a family setting. Attempts are made to decrease this tension through whatever means possible, from complete social isolation in the wilderness to numbing of the feelings through self medicating with drugs or alcohol. In extreme cases suicidal or assaultive behavior result from these intolereable feelings. Many World War II, Korean, and Vietnam veterans have struggled with this condition for years attempting to find ways to live normal lives while experiencing these symptoms. Follow up of combat veterans of World Wars I and II, Korea and Vietnam show that sizable numbers retain major symptoms of chronic PTSD decades after their original combat trauma.

The CMD's Special Committee on PTSD

At full strength the Special Committee consists of twelve VA professionals who have clincial, administrative, educational and research expertise in PTSD. Members come from the disciplines of psychiatry, psychology, social work, nursing and administration. The spectrum of VA PTSD programs are represented including the National Center for PTSD, VA Medical Centers (VAMCs), Specialized Inpatient PTSD Units, Readjustment Counseling Service, and Vet Centers. Because of recent resignations and uncertainties about the future of the National Center for PTSD, the Special Committee currently only has nine members. They include five Vietnam combat veterans and four non-veterans (one of whom is married to a Vietnam combat veteran). Present and past members of the Special Committee are among the nation's top researchers on PTSD and have frequently participated as faculty in educational programs on PTSD.

The Special Committee was appointed in late 1984 and held its first meeting in VA Central Office (VACO) 12/28/84. Since that time the full committee has met approximately four times a year, while subcommittees have conducted numerous site visits to the National Center for PTSD, Specialized Inpatient PTSD Units, VA Medical Centers (VAMCs), Vet Centers and one VA Regional Office.

The work of the CMD's Special Committee on PTSD has been documented in four reports submitted to Congress 2/1/85, 2/1/86, 2/1/87 and 10/9/87. These reports include clinical information on the treatment of PTSD in general psychiatric inpatient programs, Specialized Inpatient PTSD Units, VA outpatient facilities and Vet Centers. Since such data was not available, the Special Committee had to develop its own information through special surveys, site visits and reanalysis of data provided by the VA. Besides monitoring clinical programs, the Special Committee has conducted a system-wide survey of all PTSD disability claims filed during a twelve month period. The Special Committee has continuously reviewed all VA research and educational programs on PTSD. It has enunciated state-of-the-art methods for diagnosing PTSD and developed critera for reviewing Specialized Inpatient PTSD Units. Special Committee members have helped to develop a Program Guide for diagnosing and treating PTSD in VAMC inpatient and outpatient settings. Representatives from the Special Committee currently sit on a steering committee that plans all VA-sponsored educational programs on PTSD.

During the past year, the Special Committee in collaboration with the Great Lakes Health Services Research and Development (HSR&D) Program, developed regional packages in which the enormous amount of clinical data (presented in the Third Annual Report) has been summarized for use by each of the VA's seven Regional Directors. This was done so that the best information on PTSD treatment could be used in the MEDIPP and the MEDIPRO process for strategic planning and rational resource allocation decisions. Finally, in response to a request by the Chief Medical Director, the Special Committee conducted a site visit on 11/30/87 to the Center for Stress Recovery (CSR) at the VA Medical Center, Cleveland, Ohio (Brecksville Division) to determine how effectively it has functioned as a National Center for PTSD as mandated in Public Law 98-528.

Overview

Except for the site visit report on the Center for Stress Recovery, the seven regional data packages mentioned above and other work in progress that will appear in our Fifth Annual Report, Congress has already received approximately 400 pages of information from the Special Committee divided between our four annual reports. Therefore, I will only attempt to summarize our work accomplished during the past four years and indicate where more details can be found within our annual reports. During the remainder of this testimony I will briefly address the following topics:

1] National Center for PTSD;
2] VA Medical Center diagnosis and treatment of PTSD;
3] Vet Centers;
4] Specialized Inpatient PTSD Units;
5] PTSD Treatment Teams;
6] Research;
7] Education;
8] Veterans Benefits Issues;
9] Work in progress.

The Special Committee believes that combat-related PTSD is one of the few medical disorders specifically caused by military experience. Unlike most cases of cancer, diabetes, heart disease, schizophrenia and other disorders for which the VA provides extensive treatment, its unique etiological relationship to combat exposure should give PTSD very high priority by the VA in comparison with other programmatic requests. Such is not the case.

Review of inpatient and outpatient clinical activity devoted to PTSD in comparison with other medical and psychiatric disorders indicates great inconsistency throughout the VA system and an unacceptably low intensity of PTSD-related programs at many VAMCs (see Chapter 4 in the Second Annual Report and Chapter 2, Sections 1-5 in the Third Annual Report). In addition, since most existing VA outpatient mental health facilities are unable to meet the demand of veterans requesting treatment, the Special Committee recommended in both its 1985 and 1986 Annual Reports that additional resources be either allocated or reassigned for the diagnosis and treatment of PTSD.

National Center for PTSD

On 11/2/87 the Chief Medical Director requested that the CMD's Special Committee on PTSD conduct a programmatic review of the past performance and future capabilities of the National Center for Stress Recovery. To that end, a site visit team chaired by Patrick Boudewyns, Ph.D., visited the Center for Stress Recovery (CSR), VAMC, Brecksville, Ohio on November 15-18, 1987.

The site visitors attempted to determine how well the CSR has functioned as a National Center for PTSD as mandated in Public Law 98-528. This law states that such a National Center will; a] carry out and promote research into and train clinicians in the diagnosis and treatment of PTSD; and b] serve as a resource center and promote the exchange of information regarding all PTSD research and training activities conducted by VA and non-VA facilities.

The site visit report by Dr. Boudewyns was accepted and endorsed by the Special Committee. It concluded that the CSR has been unable to meet the Congressional mandate to function as a National Center for PTSD. Instead it has functioned primarily as a regional specialized PTSD program. It's national visibility has been limited to a number of educational activities. In general the CSR has been an isolated enterprise in which the academic and scientific environment has not been conducive to the development of a productive national program.

The Special Committee believes that a National Center for PTSD must have strong multidisciplinary research and educational programs in which all theoretical models about PTSD can be tested. Although patient care activities are important, they must be integrated into the overall research and educational goals of the National Center. To this end, a strong university affiliation is mandatory. Finally, a National Center for PTSD should not only provide leadership but should be the hub of a communication network that disseminates information on the latest research as well as on all types of treatment programs for PTSD.

The Special Committee believes that the VA has an opportunity to achieve national if not global pre-eminence in the field of PTSD through such a National Center.

VA Medical Center Diagnosis and Treatment of PTSD

In its Third Annual Report, the Special Committee finally developed the comprehensive data base on all VA clinical activities with respect to PTSD that was lacking when it began its work. the Great Lakes HSR&D Program was contracted to collect and analyze this information through funds obtained from VA Central Office. This data consisted of two components:

a] Inpatient data from analysis of the 1984 and 1985 Patient Treatment Files (PTF);

b] Outpatient data obtained through a four week nationwide survey of all VAMC outpatient facilities and all Vet Centers conducted between 9/8/86 and 10/3/86. This survey monitored 368,147 visits made by 119,353 veterans of whom 51,333 were Vietnam era veterans.

The major finding was that there is significant variability in inpatient, outpatient and Vet Center treatment devoted to PTSD across the VA system. Data has been analyzed by region, by medical district and by facility (VAMC or Vet Center). Figure 1 summarizes this data by District where the variability of diagnosing PTSD throughout the VA system can be seen.

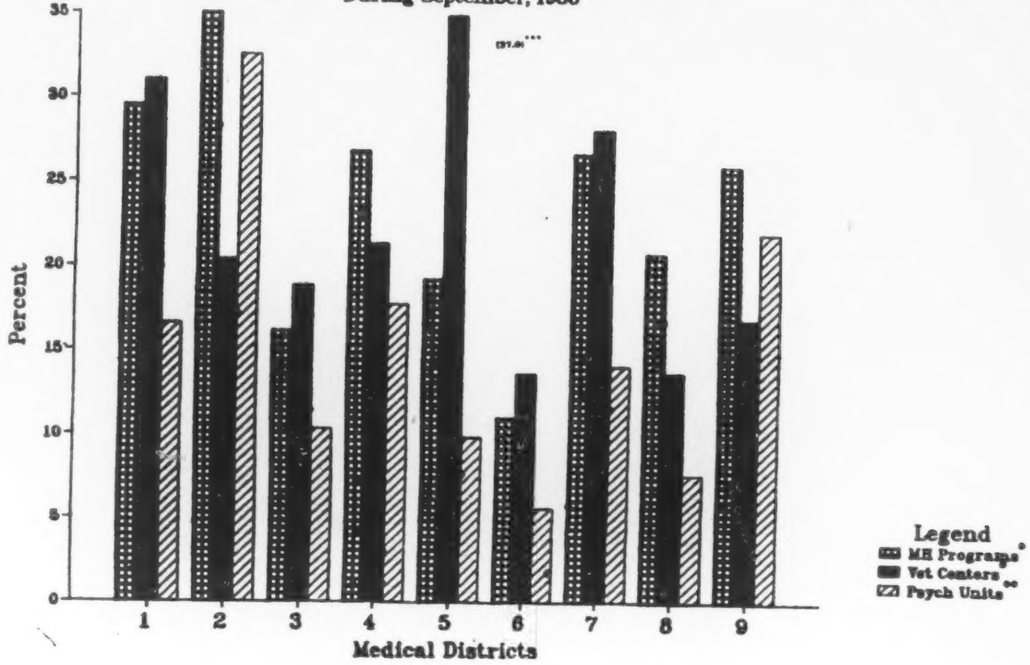
As noted above, this information has been reanalyzed and presented to each Regional Director with the hope that a more consistent clinical performance can be achieved through the regional MEDIPP and MEDIPRO processes.

Other significant findings detailed in our Third Annual Report, from the PTF and outpatient survey analyses are:

a] Between 1984 and 1985 the Patient Treatment File (PTF) shows a 39% increase in PTSD discharge diagnoses among Vietnam veterans with PTSD;

FIGURE 1

Vietnam Era Veterans with PTSD as a Percent of All Vietnam Era Veterans Seen at Mental Health Outpatient Programs, Vet Centers, and Inpatient Psychiatric Units During September, 1986



* Computed as $\frac{\text{Vietnam Era Veterans in District with PTSD Diagnosis}}{\text{Vietnam Era Veterans in District with Any Diagnosis/Problem}} \times 100$

** Computed as $\frac{\text{Vietnam Era Veterans in District Discharged with PTSD Diagnosis}}{\text{Vietnam Era Veterans in District Discharged with Any Psychiatric Diagnosis}} \times 100$

*** For districts whose rates exceeded 35, the actual number is in parentheses.

FIGURE 1 (continued)
Vietnam Era Veterans with PTSD as a Percent of All Vietnam Era Veterans Seen at Mental Health Outpatient Programs, Vet Centers, and Inpatient Psychiatric Units During September, 1988

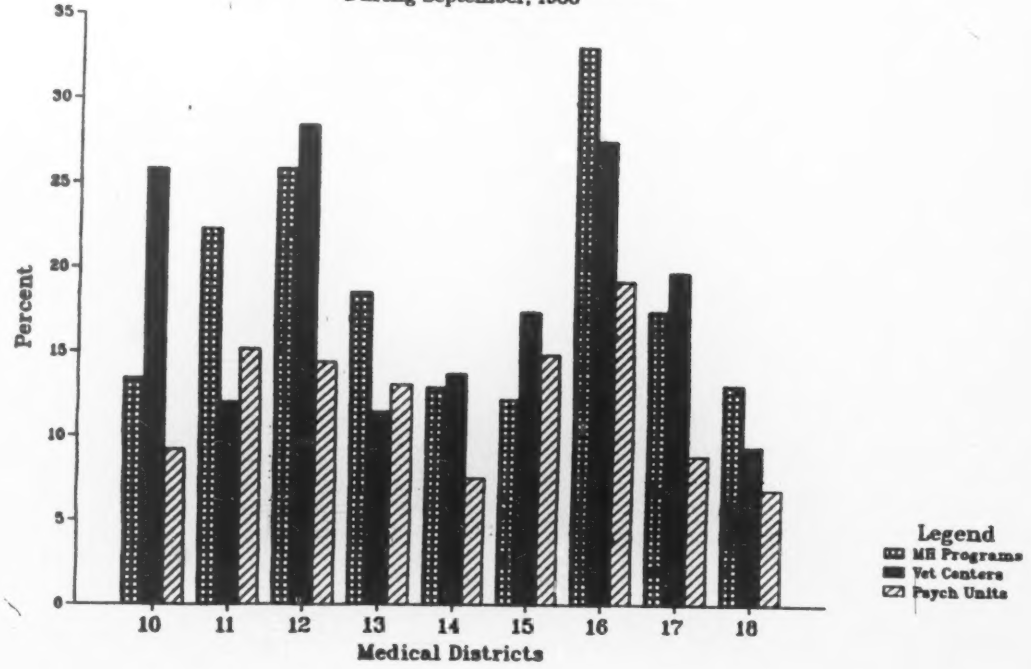
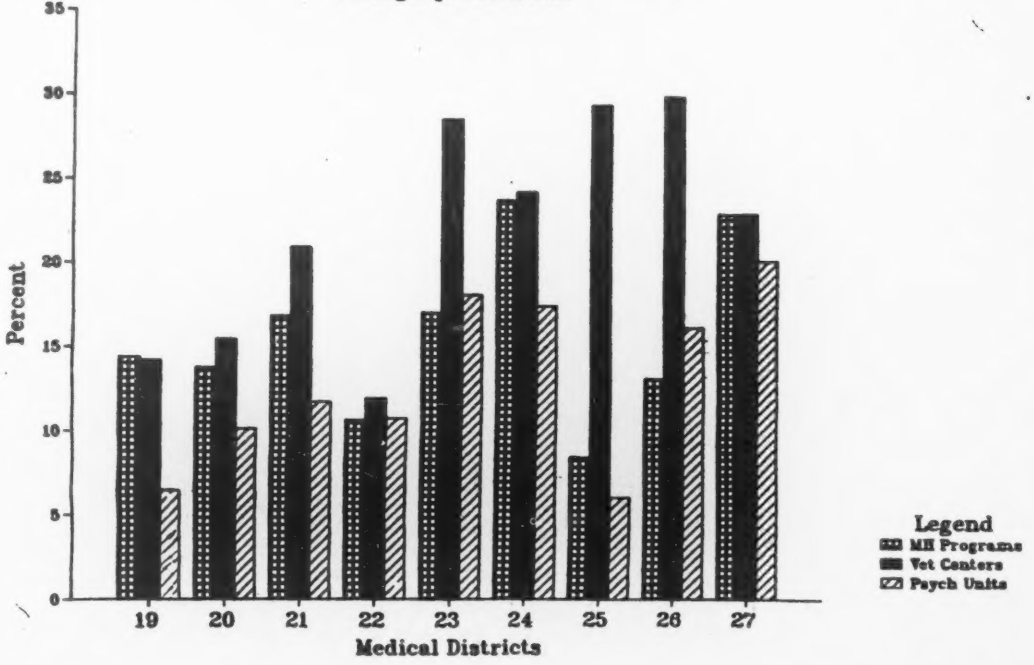


FIGURE 1 (continued)
Vietnam Era Veterans with PTSD as a Percent of All Vietnam Era Veterans Seen at Mental Health Outpatient Programs, Vet Centers, and Inpatient Psychiatric Units During September, 1986



b] 19.3% of all Veitnam Era Veterans (VEV) in outpatient mental health programs were diagnosed PTSD; 23.3% of all Vietnam Era Veterans seen in Vet Centers were diagnosed PTSD while an additional 27% of Vet Center clientele had some PTSD symptoms;

c] Clinicians failed to obtain information on a veteran patient's combat status on 11.5% of all veterans seen during the survey period in VAMC outpatient programs;

d] PTSD is the sixth most frequent diagnosis at VAMC outpatient facilities and is seen in 9.5% of veterans seen. Schizophrenia is the most frequent diagnosis in 29.4% of veterans see;

e] PTSD is the most frequent diagnosis for VEV's seen both at VAMCs and Vet Centers and is seen in 48.4% of the total;

f] Almost one-third (30.5%) of all PTSD treated in VAMC outpatient programs is found in veterans outside the Vietnam era. (21.7% from WWII, 5.1% Korean Conflict.);

g] 35.8% of Vietnam Combat Veterans seen are diagnosed PTSD in mental health outpatient programs. 25.9% of Vietnam Combat Veterans seen are diagnosed as PTSD in Vet Centers;

h] 12.6% of all WWII Combat Veterans and 9.3% of all Korean Conflict Veterans seen are diagnosed PTSD in mental health outpatient programs;

i] Patients with PTSD seen either at VAMCs or Vet Centers consistently function at a lower adaptive level (DSM-III Axis 5) than patients with other psychiatric diagnoses;

j] The presence of PTSD as a co-diagnosis along with another psychiatric diagnosis significantly decreases the level of adaptive functioning when compared to the same diagnosis without PTSD;

k] 87% of all Vet Center clients are Vietnam Era Veterans;

l] The most frequent problem seen at Vet Centers was difficulty with employment (34.7%), followed by psychological problems other than PTSD (32/6%). The presence of some PTSD symptoms was the third most frequent problem seen (27.8%); while the formal DSM-III diagnosis of PTSD ranked as seventh most frequent problem (17.7%);

m] Among veterans seen both at the Vet Centers and VAMC outpatient facilities, psychological problems other than PTSD ranks number one (41.1%), the diagnosis of PTSD number two (35/1%), drug and alcohol problems number three (32.8%), and PTSD symptoms as the fourth most common problem seen (29.9%).

Vet Center

The Special Committee assessed the Vet Center program with respect to the number of veterans served, the services utilized, the continuity of care, the quality of treatment and the specifics of service provided. Two sources of information were used. First of all, data was evaluated from the four week survey (mentioned in the previous section) conducted between 9/8/86 and 10/3/86 on the activities and services rendered to veterans at every Vet Center in the country. Secondly, site visits to 30 of the 189 Vet Centers were conducted by Special Committee members between July and September, 1986. These findings were presented in our Second Annual Report. Since then Readjustment Counseling

Service (RCS) has developed a Quality Assurance program that incorporates as performance criteria many of the Special Committee's recommendations. Furthermore, RCS now participates in the VA's Systematic External Review Program (SERP) so that it is subject to the same periodic monitoring as other VA clinical programs. The Special Committee's conclusions about the RCS program are:

a] Vet Centers have successfully provided community based services and treatment with a high level of enthusiasm, initiative and innovation. Through highly subtle and pro-active psychological and social activities that are client focused and community oriented, the Vet Centers have delivered acceptable services in a unique manner to thousands of veterans;

b] The 30 Vet Center site visits and data from the four week Vet Center Survey revealed much variability in the understood mission of Readjustment Counseling Service, in the client demand for services, in the professional training and staffing skills at each Vet Center, and in the quality of collaboration with supporting VA Medical Centers;

c] There are at least two separate missions of Readjustment Counseling Service. Some Vet Centers devote a great deal of their resources to treatment of PTSD and other psychological disorders both in the Vet Center itself and in the context of outreach services. Other Vet Centers are primarily concerned with providing social, educational and vocational counseling and other services to foster improved functioning in the family, community and workplace. All Vet Centers attempt to fulfill both missions, but the emphasis varies from one Vet Center to another;

d] Over the course of time, the multi-service orientation of Readjustment Counseling Service has become more obvious to counselors and clients. Furthermore the clinical and social needs of veterans seeking treatment at Vet Centers have become more complex and severe during recent years;

e] Differences among Vet Centers definitely reflect variations in demand for specific services, and the variability of staff skills and professional training, and differing programmatic priorities of team leaders;

f] There appears to be little integration of services or formal collaboration between Vet Centers and many of their corresponding VA Medical Centers;

g] Planning for readjustment counseling services has not become institutionalized in the Department of Medicine and Surgery. Outreach, case finding and comprehensive management, community networking, and continuity of care should be dynamically organized and strategically structured toward maintaining the maximum psychosocial adaptation of the veterans and preventing unnecessary hospitalization and utilization of resources for PTSD;

h] There is demand for PTSD treatment among approximately 20% of Vietnam Era veterans seeking care either at Vet Centers or VA Medical Centers. The demographic and clinical data acquired via the VA Patient Treatment Files for inpatients, the special Mental Health Outpatient and Vet Center Surveys for ambulatory patients, and site visits to 30 Vet Centers by members of the

Special Committee, revealed a greater volume of services to veterans for PTSD than heretofore perceived;

i] The data also revealed, probably for the first time, that wartime service and exposure to combat increase the likelihood that an individual will sustain acute and chronic, medical and psychosocial disabilities and more severe impairment in adaptive functioning than veterans not exposed to combat trauma. Results from the VA's epidemiologic study on PTSD contracted to the Research Triangle Institute are eagerly awaited in this regard;

j] The relatively low utilization of VA sponsored services for PTSD by minorities and women suggests a need for outreach and marketing to these special populations of veterans;

k] The large number of pre-Vietnam veterans being treated in VA Medical Center Mental Health Clinic for PTSD and symptoms of PTSD suggests that eligibility for Vet Center services should be expanded to include combat veterans of all wars.

Specialized Inpatient PTSD Units

Chapter 3 in the 1986 report was devoted to Specialized Inpatient PTSD Units. In order to prepare this chapter the entire Special Committee joined representatives from all 13 existing Specialized PTSD Units at the Mid-Atlantic REMC in May, 1985. In addition, the Special Committee conducted a comprehensive survey to collect data on operations from each of the Specialized PTSD Units. Finally, the Special Committee conducted site visits to six functioning units and to three VAMCs proposed for new sites.

The Special Committee made a number of recommendations based on all of this information. The major recommendation derives from Special Committee concern both about the lack of explicit standards for specialized inpatient treatment of PTSD and about the great variability observed between the 13 existing Specialized PTSD Units. Therefore, the Special Committee recommended periodic evaluation of such units with respect to: purposes and goals, program planning and design, length of stay, aftercare, administrative support, funding, geographic distribution and clinical outcome. The Special Committee cited a number of possible options for such periodic evaluation including the VA's Quality Assurance Program, the SERP review process or through specific site visits. Finally, the Special Committee expressed concern that 14 new Inpatient PTSD Units were approved in 1985 through the MEDIPP planning process despite the current lack of standardized criteria by which to evaluate either new program initiatives or ongoing programs.

The CMD supported the recommendation that Specialized PTSD Units be site visited every two years. He also supported the specific assessment criteria detailed by the Special Committee in its 1986 report (see Chapter 3, pp 25-31) and stated that they will be incorporated into program guides for Specialized PTSD Units which are currently under development. The CMD reaffirmed the importance of local control, stating that it is important to preserve the individuality of programs. He expressed concern that the Special Committee seeks "to make the programs more uniform" and cautioned against "setting firm rules which may stifle attempts to provide optimal patient care consistent with local need".

It is necessary to correct the CMD's misconception that our repeated insistence on explicit standards for Specialized Treatment Units will impose stifling conformity on such programs. We maintain that any clinical program must meet certain minimal standards and that Specialized Treatment Units are no exception. Furthermore, we are convinced that meeting such standards should in no way limit the creative options available to a specific program as it attempts to provide optimal patient care consistent with local needs.

Since 1986, several new Specialized Inpatient Units have been established, usually through local initiatives rather than VACO guidance. It seems clear that there is a need for the intensive treatment provided by Specialized Units in carefully selected cases based on clinical need. There remains a serious problem with respect to geographic distribution of such units since they currently cluster on the East Coast, the West Coast and the Great Lakes regions of the country. Only the Topeka and Little Rock programs are located in the country's mid-section and none are found in the two section of the country where the highest number of Vietnam Era Veterans reside, namely Texas and Southern California. It appears that there should be at least one Specialized PTSD Unit in each region of the country, if not two in the larger regions.

Although the CMD supported "in concept" the Special

Committee's 1986 recommendation that asessment criteria be developed for Specialized Units, there has not been any tangible progress in this regard. Finally, the Special Committee's recommendation that Specialized Units be evaluated through periodic site visits has not been implemented.

The Special Committee remains concerned that current DRG reimbursement formuli constitute a financial disincentive to establish or maintain Specialized Inpatient PTSD Units. We have reiterated that the nature of PTSD and the characteristics of intensive prolonged inpatient treatment must be taken into account in any realistic prospective funding mechanism for psychiatric care in the VA. To that end, specific DRGs with appropriate trim points and weighted work units should be developed. We recognize that this matter was addressed at the VA's Consensus Conference on RAM issues that was held during October, 1987. Although different solutions have been discussed, none has been proposed. Development of an appropriate funding mechanism will be a significant step towards assuring the availibility of Specialized Inpatient PTSD Unit treatment for those veterans who need it.

The Special Committee is currently re-evaluating all Specialized Units and will devote a chapter to this program in its Fifth Annual Report.

PTSD Treatment Teams

In each of its Annual Reports, the Special Committee has proposed:

"two mental health professional, including at least one psychiatrist, who is experienced in the diagnosis and treatment of PTSD, be provided by centrally directed FTEE to each VAMC to form the core staffing of a designated PTSD treatment team."

We further recommend that such core staffing be augmented by each VAMC to meet the needs of the local PTSD patient population. Central to this recommendation was the concept that the PTSD treatment team would: a] provide direct clinical care; b] integrate treatment offered in Vet Centers, mental hygiene clinics, VAMC general inpatient psychiatric units, and Special PTSD Inpatient Units; c] provide consultation liaison to medical and surgical units; d] supervise educational programs on PTSD; and e] monitor utilization patterns of patients with PTSD.

In his response to the Special Committee's 1985 Annual Report, the CMD "agreed in concept" with this recommendation but expressed understandable concern that such a commitment would require 344 FTEE and $22 million. He did, however, agree to support this recommendation pending the availibility of resources. Recognizing the magnitude of dollars and FTEE needed to implement this recommendation the Special Committee then suggested a gradual phase-in of PTSD treatment teams over a 5 year period on a prioritized basis. The Committee also suggested that the CMD establish this prioritization utilizing demographic and clinical data developed by the Special Committee (Chapter 4 of the 1986 Report). The CMD accepted this modification of the original recommendation and in 1987 provided funds for PTSD treatment teams at 15 VAMCs (i.e. 30 FTEE).

The Special Committee is pleased that progress has begun on this recommendation. The 15 designated VAMCs are without exception large urban academically affiliated hospitals located in cities with high populations of Vietnam veterans. This seems like a good start for implementing this recommendation. There remain, however, substantive concerns about the future of PTSD Treatment Teams with regard to: a] the timetable for implementation of this proposal; b] the methodology for monitoring the activities of PTSD Treatment Teams; and c] the process by which VAMCs will be selected for the second phase of this five year phase-in of PTSD Treatment Teams.

First of all, 15 VAMCs constitute less than 9% of the 172 VA facilities across the country. The next phase of implementation will have to include many more VAMCs if this is to be accomplished within five years as recommended by the Special Committee. Furthermore since no PTSD Treatment Teams were authorized in 1988 it is doubtful that this proposal will be completely implemented by 1992.

Secondly, if it is assumed that the phase-in of PTSD Treatment Teams will accelerate in the future based on pilot data from the 15 VAMCs currently selected, it is not clear how the VA plans to monitor the activity and productivity of these 15 PTSD Treatment Teams. In our Third Annual Report, we recommended that a methodology be established for monitoring the activity of PTSD Treatment Teams. To our knowledge, this has not been done.

Thirdly, a resource allocation process that demands augmentation of centrally directed FTEE by local VAMC FTEE favors large, well-staffed and academically affiliated hospitals over others. Furthermore, selection of the first 15 VAMCs was based enitrely on demography (the population of Vietnam veterans in the Primary Service Area (PSA) of a given VAMC). There was little consideration of a] previous productivity with regard to PTSD treatment; b] lack of productivity by VAMCs with a large population of combat veterans in their respective PSAs; and c] need for PTSD Treatment Teams by VAMCs serving many veterans but who cannot afford to designate 2 FTEE for this purpose because their overall level of mental health staffing is just too low. In short the methodology for future assignment of PTSD Treatment Teams should be based on untreated needs of combat veterans, past clinical productivity, and staffing realities in addition to the population of Vietnam veterans in a given PSA.

Finally, since the Special Committee has now generated outpatient data (see Chapter 2, Sections 3 and 5) to complement the PTF, we recommed that the CMD also utilize that information when he selects the next group of VAMCs for PTSD Treatment Teams. We are especially concerned about local policies regarding accessibility of non-service connected (NSC) veterans for outpatient treatment. We have pointed out in previous reports that many veterans with PTSD are not service connected and therefore not permitted to utilize ongoing outpatient mental health treatment at many VAMCs. (This is one reason why the distinction between Service Connected and NSC veterans was pointedly abolished in Vet Centers.) Therefore we believe that

VAMCs who have been willing to treat NSC Vietnam veterans for PTSD be viewed favorably in the selection process for the next phase of designating PTSD treatment teams.

In its Fourth Annual Report, the Special Committee expressed concerns about the possibility that progress of the 15 PTSD Treatment Teams has been variable, and in at least one case, it is doubtful whether a viable PTSD Treatment Team has been established. Failure of this program at some centers will deprive combat veterans of an important and (currently) rare treatment alternative within the VA system.

The Special Committee will devote a chapter to PTSD Treatment Teams in its Fifth Annual Report.

Research

In its First Annual Report (1985), the Special Committee expressed concern about the VA's commitment to fund research on combat-related PTSD. It noted that the VA had supported few proposals on PTSD and the Special Committee questioned the expertise of the Merit Review Board to adequately evaluate scientific proposals on PTSD. Several recommendations were offered at that time to improve this situation. Research service accepted and implemented each of these recommendations. In addition, the CMD acknowledged that PTSD represents a relatively unique combat-related maedical condition with critcal relevance to the mission of the VA. He also acknowledged the need for larger numbers of high quality investigator initiated research proposals.

The situation has continued to improve since that time. As of 4/4/88, there are presently 67 VA approved research projects on PTSD that were approved either as an initial project or a continuation project in 1987. Of these, 21 are funded by VACO research monies while 46 are funded locally by various VAMCS or by sources outside the VA. This represents a 29% increase in funding across the board for PTSD research, a 50% increase in VACO funded projects and an 11% increase in locally funded projects over 1986 levels.

In 1987 a total of $924,576 was spent on VA PTSD research projects of which $832,121 came from VA sources and $92,455 came from outside the VA.

In sum, there has been an increase in research activities and funding with regard to PTSD in the VA system over 1986 levels. This increase is in spite of the fact that Medical Research in Central Office did not act on the Special Committee's recommendation (in the Third Annual Report) to reinstitute the financial incentive associated with research in high priority areas (cost center 821/106) for PTSD. This increase in activity and funding, although still well below other more established but comparable areas such as Depression and Schizophrenia is encouraging. If it continues it should result in a better understanding of this disorder, and its apparent importance to the VA and the Military.

The Special Committee continues to recommend that Research Service re-establish the high priority financial incentive for PTSD until research funding levels for this disorder compare favorably with other comparable research areas.

Education

The Special Committee believes that the VA has the responsibility to prepare its staff to respond effectively to the veteran population suffering from PTSD. Educational programs are essential to accomplish this goal. The extraordinary variability in diagnosis and treatment of PTSD throughout the VA system suggests that a great number of VA clinicians lack the necessary conceptual and practical information needed to provide effective treatment. For this reason the Special Committee has recommended that the VA develop a national approach to training in PTSD with particular attention to those medical districts and VAMCs that are substantially below the treatment norms (with regard to percentage of PTSD diagnoses) of the system as a whole. Specific recommendations have been:

a] Targeting specialized PTSD training for those medical districts and VAMCs with disproportionately low frequency of diagnosing PTSD;

b] Conducting a systematic assessment to determine the impact of PTSD educational programs presented within the agency. One approach would be to evaluate the impact of educational programs presented to audiences with low frequency of PTSD diagnoses by monitoring subsequent changes in clinical activity;

c] Developing a list of faculty who can provide training and consultation on PTSD;

d] Updating educational aids (audiovisual material, curriculum plans, etc.) to include state-of-the-art materials;

e] Providing different levels of training given the different levels of sophistication regarding PTSD among clinicians throughout the VA system;

f] Directing educational programs toward five major audiences: VA clinical staff, VA administrative staff, military personnel, community groups and students in the health professions.

In general the CMD has supported these proposals and has accepted the Special Committee's contention that specialized PTSD training should be targeted for those medical centers with disproportionately low frequency of diagnosing PTSD. In fact, targeted training on PTSD has already been conducted in several medical districts.

During the past year, members of the Special Committee joined representatives of MH&BSS, RCS, Academic Affairs and the Center for Stress Recovery to design a national training program in PTSD. This program was completely consistent with recommendations in our earlier reports suggesting that PTSD training be targeted to VAMCs and medical districts that diagnose PTSD less frequently than elsewhere. Judging by the 1985 PTF data, this strategy has already had a favorable impact on clinical expertise throughout the VA system.

The Special Committee is concerned that except for ongoing training by Readjustment Counseling Service, few dollars have been earmarked for PTSD training dudring the current fiscal year. Having completed a series of large programs in each of the VA's seven regions in previous years, few resources have been allocated for current training initiatives. Given the system-wide variability in the capacity of VA clinicians to diagnose PTSD, ongoing training is mandatory. The Special Committee believes that current top priorities for PTSD training include:

a] A conference for PTSD Treatment Teams to upgrade clinical skills and develop performance standards;

b] Training for adjudicators and clinicians who perform and evaluate compensation and pension examinations for PTSD disability claims;

c] Training for clinicians in alcoholism and chemical abuse/dependency programs. The Special Committee's data suggests that clinicians in these programs diagnose PTSD among their clientele at a much lower rate (2.6%) than should be expected given the high rates of chemical dependency known to occur among veterans with PTSD;

d] Programs that focus on the unique problems of women and minority groups members with PTSD;

e] Continued training targeted to those Medical Districts and facilities with abnormally low rates of diagnosing PTSD.

Veterans Benefits

The Special Committee has continued to discuss PTSD disability claims with the Department of Veterans Benefits (DVB) and the Board of Veterans Appeals (BVA). Areas of concern remain the wide disparity between Regional Offices with regard to both the rates of approval for PTSD claims for service connected status and in the percentage of disability ratings granted. In addition, there is a very high reversal rate when claims disapproved by DVB have been appealed to BVA. This data, which was presented in detail in Chapter 6 of our Third Annual Report, has motivated DVB to review the performance of Regional Offices that are abnormal with regard to adjudication of PTSD disability claims. Furthermore, BVA plans to review its own data with regard to reversal rates of previously disapproved PTSD claims. We plan to present the DVB and BVA analyses in future reports after they have been made available to us.

Through discussions with DVB and BVA, the Special Committee has identified several problems in the adjudication of PTSD disability claims at different Regional Offices:

a] Adjudication Boards receiving inaccurate, inadequate or conflicting medical information to serve as the basis for the adjudication of claims;

b] The use of non-VA contract physicians who have little or no expertise in diagnosing PTSD;

c] Some BVA specialists are unfamiliar with state-of-the-art diagnostic tools for making a definitive PTSD diagnosis in contested cases.

In order to improve the adjudication of PTSD disability claims, therefore, the Special Committee recommends that all requests for compensation and pension examinations include a social and industrial survey as is currently the practice with Compensation and Pension (C&P) exams for former prisoners of war. In addition, this data base should include information from the

Vet Center when applicable. Furthermore, the Special Committee recommends that compensation and pension examinations for PTSD be performed only by VA staff psychiatrists or by physicians who have participated in PTSD training programs. The use of contract physicians with little or no knowledge of PTSD should be avoided.

The Special Committee is working actively with the Department of Veterans Benefits to improve the adjudication process for PTSD disability claims. To that end, members of the Special Committee along with a representative from DVB, recently conducted a site visit to the Los Angeles Regional Office. That site visit report, along with further recommendations on veterans benefits issues with regard to PTSD, will appear in our Fifth Annual Report.

Work In Progress

The Special Committee has continued to monitor the spectrum of PTSD clinical, educational, and research programs as well as the adjudication process for PTSD disability claims. As noted above, our Fifth Annual Report will have specific chapters on the National Center for PTSD, Specialized Inpatient PTSD Units, PTSD Treatment Teams, Research, Education and Veterans Benefits issues.

During the past year, in collaboration with Great Lakes HSR&D Program we have re-analyzed the massive inpatient, outpatient and Vet Center data base presented in our Third Annual Report and developed regional packages for each of the VA's seven Regional Directors. Members of the Special Committee have presented these individual data sets to each Regional Director and discussed how they might contribute to the MEDIPP and MEDIPRO processes. Members of the Special Committee have offered to work actively within the regional planning process so that Regional Directors will have access to the best information on PTSD treatment for strategic planning and resource allocation decisions.

Additional data analyses are currently in progress. These include:

a] Outpatient visits to VAMCs and Vet Centers by women veterans and POWs with respect to prevalence of PTSD and utilization of clinical programs;

b] Data on the total pattern of VA treatment provided to given veterans across the spectrum of PTSD programs available in VAMCs and Vet Centers. This will also show the extent to which VAMCs and Vet Centers are serving different or overlapping clinical populations;

c] Data on the professional discipline of therapists treating PTSD which will not only be useful for adminstrative purpose but also for targeting educational programs on PTSD.

The Special Committee also intends to evaluate the results of the Vietnam Veterans Readjustment Study. It is particularly interested in meshing Readjustment Study results with the clinical data on PTSD treatment presented in the Third Annual Report. Such an analysis will help the VA assess how well it is meeting the need for PTSD treatment given the Readjustment Study's data on the prevalence of PTSD in the general population.

The Special Committee believes that it has functioned in accordance with the Congressional mandate set forth in Public Law 98-528 as it continues to carry out the agenda presented in its First Annual Report. It believes that it has developed valuable information and useful recommendations.

If the mandate for the Special Committee is extended beyond 1989, the Special Committee will continue to address the matters detailed in its annual reports and outlined in this testimony. The Special Committee is particularly interested in repeating the 1986 VAMC outpatient and Vet Center surveys in 1991. Such a survey would enable the VA to see how much progress it has made in PTSD treatment over a five year period.

In summary, the CMD's Special Committee on PTSD is prepared to continue to work with VA Central Office and with the seven Regional Directors to improve the VA's capacity to treat and understand the consequences of combat-related PTSD.

Medical and Regional Office Center

White River Jct. VT 05001

Veterans Administration

July 28, 1988

In Reply Refer To

Senator Alan Cranston
Chairman
United States Senate
Committee on Veterans Affairs
Room 414, Russell Senate Office Building
Washington, DC 20510-6375

Dear Senator Cranston,

In you letter of 07/21/88 you asked what needs to be done to establish proper criteria for Specialized Inpatient Units.

As stated in my written testimony, the CMD's Special Committee on PTSD suggested a comprehensive framework for such criteria in Chapter 3 of its Second Annual Report submitted 02/01/86. I've enclosed the table from the end of that chapter which outlines nine categories of explicit criteria that we believe should be subjected to periodic review by some sort of external assessment process. These categories are: purposes and goals, program planning and development, staff preparation, admissions criteria, program design, length of stay, aftercare, geographic distribution and outcome studies.

Fred Gusman's written testimony (and program review that will appear in our Fifth Annual Report) indicated that there is great variability among current PTSD Units with respect to many of these categories. Ray Scurfield's written testimony indicates how the program at Americans Lakes might be evaluated using the attached assessment form.

I want to emphasize that the Special Committee considers this assessment form (and the detailed analysis that precedes it in Chapter 3 of our 1986 report) as a starting point for developing proper criteria for PTSD Units. I agree with the VA's stated strategy of developing a Program Guide and then initiating periodic review of each PTSD Unit. As I stated in my oral testimony explicit criteria are absolutely essential for purposes of oversight on the part of Central Office and accountability on the part of each separate program. I believe that it would not be difficult to achieve consensus on some set of criteria by experts in the field. My major concern is that it is taking a very long time to develop and implement such criteria.

Frankly, I don't believe that development of criteria is really a difficult problem. The VA has had enough experience with PTSD Units and there is enough expertise within the VA system to generate such criteria. All that is needed is determination to complete this task in a timely fashion.

I am much more concerned about implementation of criteria. It is essential that these criteria be applied to an external review process that monitors PTSD units. Criteria are tools for ensuring minimal quality of PTSD programs and benchmarks for upgrading programs that are deficient. Finally, resource allocation decisions must be based on the capacity of a given program to meet such criteria. In my opinion, the proper implementation of these criteria will be much more difficult than their development.

I hope this is helpful. I remain available to answer any additional questions that may occur to the Senate Committee on Veterans Affairs.

Sincerely,

MATTHEW J. FRIEDMAN, M.D., Ph.D.
Chairman, CMD's Special Committee on PTSD

TABLE 1

ASSESSMENT FORM FOR EVALUATING SPECILIZED PTSD UNITS

Purposes and Goals:

1. Treatment objectives and timeframe regarding PTSD symptoms.

2. Treatment objectives and timeframe regarding personal development.

Program Planning and Development:

1. Assessment of need in Primary Service Area.

2. Administrative support of Medical Center Director, Chief of Staff, and Chief, Psychiatry Service.

3. Coordination for clinical services and staffing pattern by Chiefs of Psychiatry, Social Work, Nursing, and Psychology Services.

4. Vet Center participation in program planning and development.

5. Phased Program development.

6. Consultation arrangements with established PTSD units.

Staff Preparation:

1. Practical clinical inservice training provided to staff.

2. Educational opportunities in PTSD available to staff.

3. Multidisciplinary team roles and relationships.

Admission Criteria:

1. Diagnosis of PTSD prior to admission.

2. Admission assessment including Psychosocial history, Military history, Psychiatric diagnostic examination, Psychological testing, Review of available records, and other data specific to program.

3. Pre-admission assessment of capacity to tolerate and cooperate with the program.

4. Referral to other treatment alternatives for those veterans not accepted for admission.

TABLE 1
(continued)

Program Design:

1. Specification of treatment modalities, their rationale, and organization into the program.

2. Treatment modalities addressed to psychological consequences of trauma.

3. Treatment modalities addressed to other symptoms of PTSD.

Length of Stay:

1. Periodic review of length of stay.

2. Justification, necessity for inpatient basis, rationale for duration, and outcome indicators for each major program component.

3. Review of operating costs regarding Resource Allocation Model.

Aftercare:

1. Provision for outpatient followup.

2. Utilization of alternative or transitional residential settings.

3. Utilization of community agencies.

Geographic Distribution:

1. Rank order among Medical Districts of Vietnam veteran population.

2. Coordination with treatment and training resources of tertiary care facility.

Outcome Studies:

1. Research training of staff.

2. Outcome studies or other research by staff.

Medical and Regional Office Center
White River Jct. VT 05001

Veterans Administration

July 18, 1988

In Reply Refer To

Senator Alan Cranston
Chairman, Senate Committe on Veterans' Affairs
Room 414, Russell Senate Office Building
Washington, DC 20510

Dear Senator Cranston,

Thank you for the opportunity to testify before the Senate Committee on Veterans' Affairs on July 14, 1988 to present the work of the CMD's Special Committee on PTSD. Your pertinent questions reflected a very careful reading of our four annual reports. I am particularly grateful for Elizabeth Buechler's thorough review of the Special Committee's efforts and her sensitive preparation for this hearing.

You specifically requested a written addendum to my testimony to address four points:

a] the Special Committee's suggested organization and budget for the National Center for PTSD;

b] my thoughts about the discrepant PTSD prevalence rates generated by the CDC and RTI studies respectively;

c] my thoughts about the effectiveness of Outward Bound as a treatment approach to PTSD;

d] apparent contradictions between BVA reversal rates of disapproved PTSD claims as presented by DVB (Grady Horton) and the Special Committee.

National Center for PTSD

When the Special Committee submitted its site visit report on the Center for Stress Recovery (CSR), it also suggested that a National Center for PTSD be organized very differently than the CSR to ensure that such a facility have the structural capability needed to fulfill the Congressional mandate. Eleven specific recommendations were detailed in a memorandum to the CMD dated 2/3/88. Although Dr. Boudewyns and I alluded to these recommendations in both our written and oral testimony, they are reproduced here for your convenience in Attachment A.

Attachment B presents the Special Committee's preliminary organizational scheme and budget for the National Center for PTSD which we were preparing for the CMD at the time we were invited to appear before the Sentat Veterans Affairs Committee. We were convinced that $1.4 million was insufficient if the VA seriously expected to achieve national, if not global pre-eminence in the field of PTSD through such a National Center. This total budget of $7,074,516 supports 75.0 FTEE with $2,841,518 for salary plus fringe benefits, has a recurrent educational budget of $1.0 million and a recurrent intramural research budget of $0.9 million. Start-up nonrecurring expenses are $1,104,000, with $5,970,516 recurring expenses as shown in Attachment B.

Organizationally, the Special Committee's design for a National Center for PTSD consists of five separate components shown in Attachment B, that report to the office of the Center Director (6.0 FTEE, $335,124 annually):

a] a 30 bed inpatient component (33.0 FTEE, $886,881 annually);

b] an outpatient component (12.0 FTEE, $376,288 annually);

c] a consultation-liaison component that would offer on-site consultation to VA PTSD programs nationwide as well as more traditional services within the VAMC that houses the National Center (7.0 FTEE, $259,282 annually);

d] a research component that would administer the intramural research budget, carry out on-site PTSD research, foster collaboration with researchers in the affiliated medical school, and promote research and collaboration with other VA PTSD investigators. The research component will also be responsible for monitoring ongoing PTSD clinical activity throughout the VA System (annual PTF analyses, outpatient surveys, Vet Center surveys, etc). Additional analyses of RTI data mentioned during the 7/14/88 hearings could also be carried out by the research component (8.0 FTEE, $323,958 annually);

e] an educational component that would assume major responsibility for an ongoing national training program in PTSD for DM&S and DVB personnel. In addition the educational component would be responsible for networking and achieving frequent communication between all PTSD programs across the nation (10.0 FTEE, $323.549 annually).

Prevalence of PTSD: CDC vs RTI Data

I believe that you have already received an explanation for the descrepancies between CDC and RTI prevalence data from Dr. Schlenger. In short, the CDC study is flawed methodologically for three reasons:

a] its sample was limited to army veterans who served no more than one tour in Vietnam. Since the risk of PTSD is directly related to combat exposure, two and three tour combat veterans are at higher risk to develop PTSD than single tour veterans. Furthermore, marines as a group certainly had at least as great a risk to face combat trauma as army troops;

b] the DIS is an inadequate instrument for detecting PTSD as shown by the very careful preliminary studies of the RTI group. The CDC study was undertaken before it became known that the DIS was not sufficiently sensitive to detect PTSD in a population sample;

c] the CDC failed to recognize the seminal work of Dr. Keane and associates on the characteristic MMPI profile of combat veterans with PTSD. Specifically, PTSD is associated with marked elevations of the MMPI F-Scale. The CDC researchers arbitrarily eliminated combat veterans with F scores above 70 in their MMPI analyses although Dr. Keane has shown that combat veterans with PTSD average F scores around 88.

Outward Bound

I may be the first psychiatrist in the VA to have used Outward Bound for psychiatric (including PTSD) and alcoholic patients. Since Outward Bound used to have an office at Dartmouth College I was able to initiate clinical trials for VA psychiatric patients more than six years ago. I did so because I believe that Outward Bound-type programs may have a useful therapeutic role in a number of psychiatric disorders including PTSD.

Unfortunately, this remains only a belief at this time. The necessary evaluation research has not been done. I have discussed this matter many times with Bob Rheault during the past five years. Currently we lack scientific evidence that Outward Bound either has a measurable impact on clinical progress or that it is "cost-effective" as stated by Mr. Rheault at the 7/14/88 hearing.

In summary, it remains an open question whether Outward Bound is clinically efficacious. I frankly believe that it is and I am confident that Mr. Rheault's claims will be validated scientifically. Therefore, I was pleased to learn at the 7/14/88 hearing that the efficacy of Outward Bound will finally be evaluated systematically by both the American Lakes and Augusta inpatient PTSD programs.

Contrdadictory BVA Reversal Rates of PTSD Claims: DVB vs the Special Committee

I was frankly surprised to hear Grady Horton dispute the findings presented in the Special Committee's Third Annual Report (pages 217-220).; In that report we presented detailed information (see especially Tables 21 and 22). Our statement that 86% of PTSD cases appealed to the BVA had been reversed has never before been challenged by DVB although they have had our report since 2/1/87 and have met with us several times since then. I can only offer one possible explanation for Mr. Horton's surprising statement at the hearing that only 14% (rather than 86%) of PTSD cases appealed to BVA have been reversed. I believe that he misinterpreted the question. This seems like a plausible explanation since I understand that the overall reversal rate of all disability claims appealed to BVA is 14%. It is only when you focus specifically on PTSD claims that the 86% BVA reversal rate emerges. As shown in Table 21 (page 218) of our Third Annual Report, 272 out of 316 claims appealed to BVA were reversed or 86%. That Table lists the VA Regional Offices and the number of claims reversed by BVA from each one.

The plausibility of these findings is enhanced by FY1987 DVB data recently made available to the Special Committee. In FY1987 655 out of 841 (or 78%) of PTSD claims appealed to BVA were reversed. This is certainly much closer to the 86% figure (from FY1986) cited in our Third Annual Report than the 14% figure mentioned by Mr. Horton at the hearing on 7/14/88. I should add that all of this information comes from data provided by DVB to the Special Committee. The FY1987 data coming specifically from a report dated 1/23/88 entitled "Profile of Post-Traumatic Stress Disorder; Coin:CP-136".

Having clarified the matter of contradictory BVA reversal rates of PTSD claims, I want to emphasize that this matter needs to be placed in its proper perspective because only a very small number of all disapproved PTSD claims were actually appealed to BVA. As stated on page 217 (paragraph 1) of our Third Annual Report out of 4,421 disapproved PTSD claims only 316 or 6% were actually appealed to BVA. Similarly in FY1987 out of 11,603 disapproved PTSD claims only 841 or 3% were actually appealed to BVA. Furthermore in FY1987 out of 23,644 total PTSD disability claims, 14,014 or 56% were approved by DVB. Therefore, I completely agree with Mr. Horton's major point that the BVA reversal rate needs to be interpreted very carefully since it applies to such a small percentage of all disapproved PTSD claims. The Special Committee is more concerned about those specific Regional Offices with high BVA reversal rates (Table 21, page 218, Third Annual Report) than it is about the across the board BVA reversal rate for DVB as a whole.

Before leaving the matter of veterans' benefits I would like to reiterate for the record, that DVB has been extremely helpful and forthcoming in all interaction with the Special Committee. I am convinced that DVB is seriously committed to improving the consistency of the adjudication of PTSD claims across the nation. I expect that DVB will continue to work closely with the Special Committee to improve the quality of PTSD compensation and pension examinations, to develop educational programs and videotapes to upgrade skills of adjudicators as well as examining physicians, and to improve the quality of information set before each adjudication board with respect to each PTSD disability claim.

I believe that I have fully answered the four questions you mentioned during my testimony. In closing, let me once again thank you for your interest, and concern. I will be very happy to address any additional matters if you wish.

Sincerely,

Matthew J Friedman

Matthew J. Friedman, M.D., Ph.D.
Chairman, CMD's Special Committee on PTSD
Chief, Psychiatry Service
Veterans Administration Hospital
Professor of Psychiatry and
Pharmacology
Dartmouth Medical School
Hanover, NH 03756

ATTACHMENT A

Towards a National Center for PTSD

The Special Committee proposes eleven recommendations on the future mission, operation and organization of a National Center for PTSD:

1. There should be a national advisory committee composed of experts in biological, psychological and social aspects of PTSD who will guide the National Center for PTSD and ensure that its research, educational and clinical activities encompass the bio-psycho-social comprehensive approach to psychiatric disorders. The advisory committee should meet at least once a year with the Director of the National Center to assure that the direction of the National Center is consistent with its goals. The initial action of the advisory committee should be to assist the CMD in selecting an appropriate person for appointment as Director of the National Center.

2. Since the National Center should perform research and educational functions as well as clinical activities, its Director should report directly to the Chief Medical Director. Such an organizational relationship would make it possible for the National Center to develop the many necessary productive collaborative arrangements with different divisions of the VA's Department of Medicine and Surgery. The Director would need to have immediate and direct access to the ADCMD for Operations as well as the Directors of MH&BSS, RCS, Academic Affairs and Medical Research Service. This recommendation is based in part on the experience of the Special Committee; we believe that our direct access to the Chief Medical Director was a key factor in our ability to work collaboratively with many divisions within DM&S as well as DVB.

3. The National Center should control its own intramural research, educational and training budget. This budget should be exempt from RAM constraints.

4. Non-research patient care activities conducted by the National Center should be funded out of patient care dollars that are separate from the research, education and training budget mentioned above. Such clinical activities would be subject to the RAM. (This model can already be found within the VA in GRECC units.)

5. The National Center need not be located entirely at one site. A more effective approach might consist of a multi-site consortium in which several sites are programmatically integrated by a major center. Such an organization would be well-suited to carry out multidisciplinary cooperative studies.

6. There should be a strong medical school affiliation in which the activities of the National Center are well integrated with academic interests of the affiliated Department of Psychiatry.

7. The Director of the National Center for PTSD should report annually to the Chief Medical Director and to the national advisory committee. Satisfactory review of the National Center's activities should be a condition for continued funding.

8. The multidisciplinary activities in research, education and training should comprehensively reflect a range of applicable theoretical and clinical approaches. The National Center should foster an intellectual atmosphere in which all theoretical models of PTSD can be tested. By virtue of its multidisciplinary, eclectic and non-doctrinaire orientation, it should provide laboratories for testing all hypothetical approaches to PTSD within the bio-psycho-social spectrum.

9. The National Center for PTSD should assume a leadership role in promoting educational activities with respect to PTSD. In this regard it should collaborate with Academic Affairs and the RMECs to plan and implement such programs.

10. The National Center should serve as a clearinghouse to disseminate information on national research and clinical activities on PTSD. It should be the hub of a communications network through which information is exchanged on the latest research as well as on all types of treatment programs on PTSD.

11. The National Center should have access to a Specialized Inpatient PTSD Unit in which to conduct research as well as to provide patient care. It should be clearly understood, however, that patient care activities are not the main focus of the center (as stated in the law) and that the research and education goals of the National Center for PTSD should not be compromised by local fiscal and clinical needs.

ATTACHMENT B

NATIONAL CENTER FOR PTSD

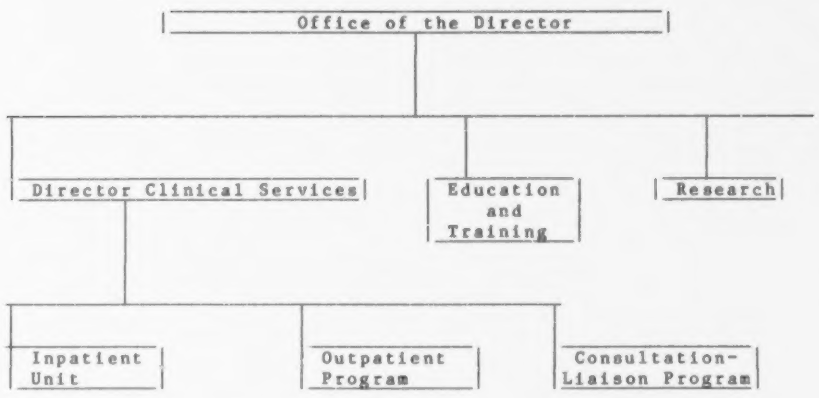
BUDGET PROPOSAL AND ORGANIZATIONAL CHART

Page 1	Budget Summary
Page 2	Organizational Outline with Budget by Division
Page 3	Organizational Chart
Page 4	Staffing Summary
Pages 5 and 6	Staffing and Budget Summary by Division

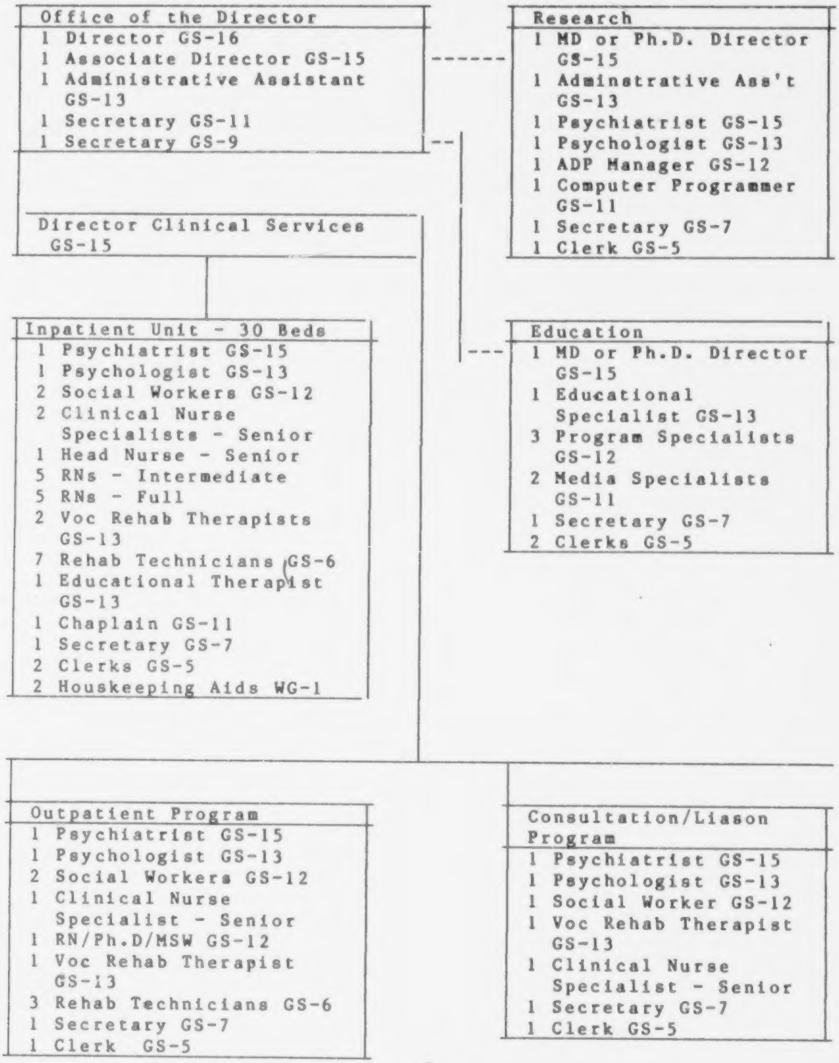
BUDGET SUMMARY

Personal Services		2,408,064	- Recurring
Fringe Benefits (18%)		433,452	- Recurring
Relocation/Renovation		440,000	- Nonrecurring
All Other		469,000	- Recurring
ADP		160,000	- Recurring
Equipment		150,000	- Nonrecurring
M&R		500,000	- Nonrecurring
Travel			
	Relocation	14,000	- Nonrecurring
	Adminstrative	600,000	- Recurring
	Education	1,000,000	- Recurring
Research			
	Intramural	900,000	- Recurring
	Extramural	(to be determined)	- Recurring
Total		7,074,516	

Recurring Budget	5,970,516
Nonrecurring Budget	1,104,000
Total	7,074,516


Office of the Director
Director Clinical Services
Education and Training
Research
Inpatient Unit
Outpatient Program
Consultation-Liaison Program

Division	FTEE	Salary
Office of the Director	6.0	335,124
Inpatient Unit	33.0	886,881
Outpatient Program	12.0	376,288
Consultation-Liaison	7.0	259,282
Education	10.0	323,549
Research	8.0	323,958
Total	75.0	2,408,064



Office of the Director
1 Director GS-16
1 Associate Director GS-15
1 Administrative Assistant GS-13
1 Secretary GS-11
1 Secretary GS-9

Research
1 MD or Ph.D. Director GS-15
1 Adminstrative Ass't GS-13
1 Psychiatrist GS-15
1 Psychologist GS-13
1 ADP Manager GS-12
1 Computer Programmer GS-11
1 Secretary GS-7
1 Clerk GS-5

Director Clinical Services
GS-15

Inpatient Unit - 30 Beds
1 Psychiatrist GS-15
1 Psychologist GS-13
2 Social Workers GS-12
2 Clinical Nurse Specialists - Senior
1 Head Nurse - Senior
5 RNs - Intermediate
5 RNs - Full
2 Voc Rehab Therapists GS-13
7 Rehab Technicians GS-6
1 Educational Therapist GS-13
1 Chaplain GS-11
1 Secretary GS-7
2 Clerks GS-5
2 Houskeeping Aids WG-1

Education
1 MD or Ph.D. Director GS-15
1 Educational Specialist GS-13
3 Program Specialists GS-12
2 Media Specialists GS-11
1 Secretary GS-7
2 Clerks GS-5

Outpatient Program
1 Psychiatrist GS-15
1 Psychologist GS-13
2 Social Workers GS-12
1 Clinical Nurse Specialist - Senior
1 RN/Ph.D/MSW GS-12
1 Voc Rehab Therapist GS-13
3 Rehab Technicians GS-6
1 Secretary GS-7
1 Clerk GS-5

Consultation/Liason Program
1 Psychiatrist GS-15
1 Psychologist GS-13
1 Social Worker GS-12
1 Voc Rehab Therapist GS-13
1 Clinical Nurse Specialist - Senior
1 Secretary GS-7
1 Clerk GS-5

STAFFING SUMMARY

FTEE	Position	Individual Salary	Total Salary
1	Director GS-16	85,000	85,000
7	Psychiatrists GS-15	80,000	560,000
4	Psychologist GS-13	39,501	158,004
5	Social Workers GS-12	33,218	166,090
4	Voc Rehab Therapists GS-13	39,501	158,004
4	Clinical Nurse Specialists Senior	33,218	132,872
1	Head Nurse Senior	33,218	33,218
5	Registered Nurses Intermediate	27,716	138,580
5	Registered Nurses Full	22,907	114,535
10	Rehab Technicians GS-6	16,857	168,570
2	Educational Specialists GS-13	39,501	79,002
1	RN/Ph.D/MSW Outpatient Therapist GS-12	33,218	33,218
1	Chaplain GS-11	27,716	27,716
3	Educational Program Specialists GS-12	33,218	66,436
2	Media Specialist GS-11	27,716	55,432
1	ADP Manager GS-12	33,218	33,218
1	Computer Programmer GS-11	27,716	27,716
1	Administrative Assistant GS-14	46,679	46,679
1	Administrative Assistant GS-13	39,501	39,501
1	Executive Secretary GS-11	27,716	27,716
1	Secretary GS-9	22,907	22,907
5	Secretaries GS-7	18,725	93,625
7	Clerks GS-5	15,118	105,826
2	Housekeeping Aids WG-1	17,098	34,196
75.0 FTEE			2,408,064

STAFFING SUMMARY
Office of the Director

FTEE	Position	Individual Salary	Total Salary
1	Director Psychiatrist GS-16	85,000	85,000
1	Associate Director GS-15	80,000	80,000
1	Director of Clinical Services GS-15	80,000	80,000
1	Administrative Assistant GS-13	39,501	39,501
1	Executive Secretary GS-11	27,716	27,716
1	Secretary GS-9	22,907	22,907
6.0	Total FTEE		335,124

Inpatient Unit - 30 Beds

FTEE	Position	Individual Salary	Total Salary
1	Psychiatrist GS-15	80,000	80,000
1	Psychologist GS-13	39,501	39,501
2	Social Workers GS-12	33,218	66,436
2	Clinical Nurse Specialist Senior	33,218	66,436
1	Head Nurse Senior	33,218	33,218
5	Nurses Intermediate	27,716	139,380
5	Nurses Full	22,907	114,535
2	Voc Rehab Therapists GS-13	39,501	79,002
7	Rehab Technicians GS-6	16,857	117,999
1	Educational Therapist GS-13	39,501	39,501
1	Chaplain GS-11	27,716	27,716
1	Secretary GS-7	18,725	18,725
2	Clerks GS-5	15,118	30,236
2	Housekeeping Aids WG-1	17,098	34,196
33.0	Total FTEE		886,881

Outpatient Program

FTEE	Position	Individual Salary	Total Salary
1	Psychiatrist GS-15	80,000	80,000
1	Psychologist GS-13	39,501	39,501
2	Social Workers GS-12	33,218	66,436
1	Clinical Nurse Specialist Senior	33,218	33,218
1	RN/Ph.D/MSW GS-12	33,218	33,218
1	Voc Rehab Therapist GS-13	39,501	39,501
3	Rehab Technicians GS-6	16,857	50,571
1	Secretary GS-7	18,725	18,725
1	Clerk GS-5	15,118	15,118
12.0	Total FTEE		376,288

STAFFING SUMMARY
Consultation/Liaison

FTEE	Position	Individual Salary	Total Salary
1	Psychiatrist GS-15	80,000	80,000
1	Psychologist GS-13	39,501	39,501
1	Social Worker GS-12	33,218	33,218
1	Voc Rehab Therapist GS-13	39,401	39,501
1	Clinical Nurse Specialist Senior	33,218	33,218
1	Secretary GS-7	18,726	18,726
1	Clerk GS-5	15,118	15,118
7.0	Total FTEE		259,282
	Education		
1	MD or Ph.D. Director GS-15	80,000	80,000
1	Educational Specialist GS-13	39,501	39,501
3	Program Specialists GS-12	33,218	99,654
2	Media Specialists GS-11	27,716	55,432
1	Secretary GS-7	18,726	18,726
2	Clerks GS-5	15,118	30,236
10.0	Total FTEE		323,549
	Research		
1	MD or Ph.D Director GS-15	80,000	80,000
1	Administrative Assistant GS-14	46,679	46,679
1	Physician GS-15	80,000	80,000
1	Psychologist GS-13	39,501	39,501
1	ADP Manager GS-12	33,218	33,218
1	Computer Programmer GS-11	27,716	27,716
1	Secretary GS-7	18,726	18,726
1	Clerk GS-5	15,118	15,118
8.0	Total FTEE		323,958

TESTIMONY OF

DR. PATRICK A. BOUDEWYNS

Chief, Psychology Service

VA Medical Center, Augusta, Georgia

on behalf of the

Veterans Administration

before the

UNITED STATES SENATE VETERANS' AFFAIRS COMMITTEE

July 16, 1988

Mr. Chairman, I am Patrick A. Boudewyns, Chief of the Psychology Service at the VA Medical Center in Augusta, Georgia. I am also a member of the Chief Medical Director's (CMD) Special Committee on Post Traumatic Stress Disorder and was Chairman of a task force of members from the CMD's special committee assigned to conduct a site visit to the National Center for stress recovery at the VA Medical Center Cleveland, Ohio (Brecksville Division). This is a report on that visit which was carried out from November 16-18, 1987. Other members of that task force were Alfonso Batres, MSW, Ph.D., Joan Furey, R.N., M.A., Fred Gusman, MSW, and Lawrence Kolb, M.D.. Also Laurent Lehmann, M.D. at the request of the Chief Medical Director, accompanied the task force as the Central Office representative from Mental Health and Behavioral Sciences Services. Just prior to the first meeting at the medical center on the morning of November 16, 1987, Dr. Kolb was called away on a personal emergency and was unable to return. I assumed Dr. Kolb's responsibilities for the remainder of the visit. The committee's objective was to evaluate the national Center for Stress Recovery, hereafter called the Center for Stress Recovery (CSR), in accordance with the mandate of the law which created the center. This law, Public Law 98-528, mandates the CSR to:

> "Carry out and promote the training of health care and related personnel in, and research into, the causes and diagnosis of PTSD and the treatment of veterans with PTSD and to serve as a resource center for, and promote and seek to coordinate the exchange of information regarding all research and training activities carried out by the Veterans Administration and by other federal and non-federal entities with respect to post-traumatic stress disorder."

This testimony is based primarily on: (1) excerpts from the task force's report and (2) a report of the CMD's Special Committee on PTSD to the CMD. The task force's report is dated January 19, 1988 and the Special Committee's report is dated February 3, 1988.

Prior to and during the site visit the task force was supplied with several pieces of information including:

1. a field survey of the thirteen special PTSD treatment units, conducted by Mr. Gusman prior to going to Cleveland, which requested information about the special units' perception of the CSR's networking function;

2. a program description supplied by the CSR staff which included a section on CSR staff publication and presentation;

3. an appendix to that program description that included among other items reprints, preprints, and case studies;

4. vitas of key CSR staff personnel;

5. a cost summary of the program supplied by the Fiscal Officer;

6. CSR trainees including one Psychiatry resident and one Psychology intern;

7. Mid Atlantic Regional Medical Education Center officials including Robert Frymier, M.D., Robert Means, Ph.D., Joseph Nagel, Ph.D., and Richard Zucco, M.A.;

8. faculty from Case Western Reserve University of medicine, including Richard Corradi, M.D., Acting Chairman, Howard Sudak, M.D. and Luis Ramirez, M.D.;

9. Dr. Alan Young, a Medical Anthropologist from the Department Anthropology at Case Western;

10. two Vet Center team leaders from local Vet Centers.

11. several former members of the CSR clinical staff.

Program Overview

The CSR was developed originally at Cleveland as a local center with local initiative and opened in July 1984 just prior to the enactment of the Public Law 98-528. Shortly after this the CSR began development of a proposal that would make this local program a regional resource. At about the same time this regional proposal was sent to Central Office, Public Law 98-528 was enacted. Since the CSR Regional proposal had goals and objectives that appeared to meet the requirement of the law for a national center, Cleveland was asked by Central Office officials to expand the focus of their proposal to meet the requirements of a national center. The VA Medical Center at Cleveland was then provided with an additional $1,000,000 for 30 FTEE and $400,000 for all other expenses to upgrade the already existing local center to the National Center for Stress Recovery in October 1984.

According to background information supplied by Mr. Zamberlin and Dr. Wolcott, the proposal from Cleveland for a national center for stress recovery had the following objective and goals:

1. the integration of a variety of effective therapeutic strategies.

2. greater involvement of the Vet Centers with the Medical Center.

3. provision for the development of training, evaluation, and research for the Medical Center and other VA facilities.

4. to develop a comprehensive center for the study and treatment of post-traumatic stress.

5. to study the efficiency of existing innovative treatments.

6. to develop a working partnership with existing community resources, particularly the Vet Centers, to provide additional vocational, social and readjustment services to veterans with PTSD.

7. to provide both consultation and treatment for the Medical Center and other VA facilities on assessment and treatment of stress disorders.

8. to facilitate research in acute and chronic reactions to stress.

9. to develop an educational program in the assessment and treatment of PTSD.

10. to develop an ambulatory care program: (1) to provide continuing care and (2) for patients who need treatment but do not require hospitalization.

By January 1985 the core staff was in place and the process of team building continued until March 1985 when the first patients were admitted. During that first year there was apparently considerable conflicts among the staff of the center which resulted in an almost complete turnover of staff. Originally the Medical Center allocated 28 FTEE to the local program, and with the advent of the national Center, 30 more FTEE were added to the program's core staffing, for a total of 58 FTEE. According to the Medical Center Director, however, CSR was given a ceiling of only 44 FTEE between the time they hired the first Program Director, Mr. Jack Smith and January 1985. Furthermore, not all of the 44 positions were filled, due apparently to problems in recruiting.

During this time period, there was apparently little interaction between the CSR staff and other services within the center. Service chiefs saw the center as a closed organization operating in isolation. Attempts to establish communication with the CSR were frustrating and unsuccessful. The CSR was perceived as an exclusive operation that was granted privileges not available to other programs. Initially the assessment and screening process used by the CSR seemed lengthy and elaborate and referring services were unable to have patients admitted for treatment. The center did not accept patients with psychiatric codiagnosis (in addition to a diagnosis of PTSD) but referred such patients to outpatient and general psychiatric services.

Relationships between the CSR and other services appear to be somewhat better now. One continuing source of disharmony between the CSR and other services is the impact of the RAM on staffing and workloads throughout the medical center. Also, most of the people outside the CSR viewed, Jack Smith, the original Director of the CSR (resigned) as wishing to maintain an aloofness from the rest of the medical center. Likewise the staff within the CSR complained that he was very often on travel status and not available to them. These stresses were apparently the cause for much of the early turnover, especially among the professional ranks of the CSR staff.

At the present time the CSR is organized under a newly appointed Director (Acting) Dr. Paul Emery and is structured into four sections: (1) Inpatient Unit; (2) Outpatient Unit; (3) Assessment and Evaluation and (4) Research and Education. Dr. Robert Erickson, a Clinical Psychologist, is coordinator of the Inpatient Unit; Mr. Richard Clewell, a Chaplain, is coordinator of the Outpatient Unit; Dr. Richard Shurell, a Psychologist, is coordinator of the Research and Education program. There was no coordinator of the Assessment and Evaluation section at the time of the visit. At the present time, according to personnel, there are four positions filled and active in the administrative offices under Director, Dr. Emery. These include: Dr. Dennis MacCobie, Assistant Director, a secretary and a clerk. According to the CSR staff, the Research and Education unit at the present time has only one FTEE in it, Dr. Richard Shurell. However, the Personnel Service supplied us with a breakdown of FTEE by unit which includes an Education section. The discrepancy may be due to a recent loss in the section. Also, the CSR is presently recruiting for a research psychologist for that section. The outpatient unit includes 8.4 FTEE including: the Coordinator, Mr. Clewell; a Social Worker; three Vocational Rehabilitation Specialists; two Rehabilitation Specialists; and two Clinical Specialist. The Social Worker and Clinical Specialists are part time. The inpatient unit is staffed by two psychologists; a physician's assistant; a social worker; three readjustment counselors; three rehab technicians; a head nurse; an assistant head nurse; and eight staff nurses. All of the above totals 33.6 TREE for the entire CSR. According to information supplied by Fiscal Service and by Personnel, presently the authorized ceiling for the CSR is 44 FTEE. However, the CSR Director states that he has not been authorized to recruit for the remaining 10.4 positions yet. At the present time there is no one in the assessment and evaluation section, although is our understanding that this section could be reactivated in the future.

Findings

Based on material supplied by VACO, the Brecksville VAMC, the SCR and on meetings with many key personnel seen at Brecksville during the site visit, the task force came to the following conclusions and recommendation:

Conclusions

1. The CSR has never functioned as a "national center" in any of the areas of concern including research, education, patient care and communication and networking. The program at the CSR is basically a local program that is just beginning to serve local needs.

2. Although some preliminary efforts at national involvement have been made by some CSR staff, it is clear that the academic/scientific environment at Brecksville is not conducive to the development of a productive national program in PTSD.

3. The present treatment approach at the CSR is too highly structured and rigid to serve the local needs.

Recommendations

1. The Special Committee should advise the CMD to immediately remove the designation "national" from the title of the Center for Stress Recovery. The CSR has not functioned as a national center nor can it be expected to under the current fiscal system. Expressions from the other specialized PTSD units indicate a lack of coordination and support for the CSR. Failure to remove the word "national" would perpetuate the illusion the the CSR is something more than a local PTSD treatment operation as it is currently, and which it has been since its inception.

2. That the CSR not be allowed to implement the lengthy, detailed and expensive educational package it wants to disseminate in regard to the model at this time. At present the model is only one of the number of theoretical-clinical approaches to PTSD and its treatment. It would be unscientific and a disservice to PTSD suffers to export this treatment system as "the" treatment for PTSD. The model should be reported in the literature so that others can study it.

3. That the Special Committee request that a national center or consortium for PTSD that can truly meet congressional mandates be made operational. In developing such a center or group of centers (consortium), proven expertise in clinical care, research and education must be a part of the enterprise. Integration of the establishment with one or more university/health science centers is essential from the beginning of the program. Funding and staffing must be adequate for a national center while actually supporting the program from local patient care resources. Such a center should allow the Program Director administrative and fiscal autonomy with the expectation of complete accountability of center office.

4. If such a national center is established, some form of monitoring mechanism at the Central Office level should be used to assure compliance with established guidelines.

5. If such a center is established, it should be done via a request for proposal (RFP) procedure commonly used for other national research, training and patient care programs that are established by national bureaucracies.

6. The treatment program at the CSR should be less rigid and include the use of other more common treatment methodologies (e.g. vocational counseling; alcohol and drug abuse treatment) where appropriate if it is to serve local needs well. The CSR should also be more open to treating PTSD sufferers with Axis II diagnoses in order to better serve local needs.

CMD Special Committee Recommendations

After evaluating the site visit report, the entire Chief Medical Director's Special Committee on PTSD proposed the following eleven recommendations and five conclusions on the future mission, operation and organization of a National Center for PTSD to the Chief Medical Director.

1. There should be a national advisory committee composed of experts in biological, psychological and social aspects of PTSD who will guide the National Center for PTSD and ensure that is research, educational and clinical activities encompass the bio-psycho-social comprehensive approach to psychiatric disorders. The advisory committee should meet at least once a year with the Director of the National Center is consistent with its goals. The initial action of the advisory committee should be to assist the CMD in selecting an appropriate person for appointment as Director of the National Center.

2. Since the National Center should perform research and educational functions as well as clinical activities, its Director should report directly to the Chief Medical Director. Such an organizational relationship would make it possible for the National Center to develop the many necessary productive collaborative arrangement with different division of the VA's Department of Medicine and Surgery. The Director would need to have immediate and direct access to the ADCMD for Operations as well as the Directors of MH&BSS, RCS, Academic Affairs and Medical Research Service. This recommendation is based in part of the experience of the Special Committee; we believe that our direct access to the Chief Medical Director was a key factor in our ability to work cooperatively with many divisions within DM&S as well as DVB.

3. The National Center should control its own intramural research, educational and training budget. This budget should be exempt from RAM constraints.

4. Non-research patient care activities conducted by the National Center should be funded out of patient care dollars that are separate from the research, education and training budget mentioned above. Such clinical activities would be subject to the RAM. (This model can already be found within the VA in GRECC units.)

5. The National Center need not be located entirely at one site. A more effective approach might consist of multi-site consortium in which several sites are programmatically integrated by a major center. Such an organization would be well-suited to carry out multi-disciplinary cooperative studies.

6. There should be a strong medical school affiliation in which the activities of the National Center are well integrated with academic interests of the affiliated Department of Psychiatry.

7. The Director of the National Center for PTSD should report annually to the Chief Medical Director and to the national advisory committee. Satisfactory review of the National Center's activities should be a condition for continued funding.

8. The multidisciplinary activities in research, education and training should comprehensively reflect a range of applicable theoretical and clinical approaches. The National Center should foster an intellectual atmosphere in which all theoretical models of PTSD can be tested. By virtue of its multidisicplinary, eclectic and non-doctrinaire orientation, it should provide laboratories for testing all hypothetical approaches to PTSD within the bio-psycho-social spectrum.

9. The National Center for PTSD should assume a leadership role in promoting educational activities with respect to PTSD. In this regard it should collaborate with Academic Affairs and the RMECs to plan and implement such programs.

10. The National Center should serve as a clearinghouse to disseminate information on national research and clinical activities on PTSD. It should be the hub of a communications network through which information is exchanged on the latest research as well as on all types of treatment programs. PTSD.

11. The National Center should have access to a Specialized Inpatient PTSD Unit in which to conduct research as well as to provide patient care. It should be clearly understood, however, that patient care activities are not the main focus

of the center (as stated in the law), and that the research and education goals of the National Center for PTSD should not be compromised by local fiscal and clinical needs.

Has the CSR Functioned as a National Center for PTSD?

The Special Committee believes that attempts to establish a National Center for PTSD will fail unless they are conducted within the framework defined by these eleven recommendations. It is instructive to evaluate the CSR by these eleven criteria, in order to better understand how is has been unable to meet the Congressional mandate. Administratively, the CSR was located at the Brecksville, VAMC and subject tot he same controls and constraints as any other DM&S hospital program. Failure to protect the CSR from RAM cost accounting and subjecting it to the authority of local officials at Brecksville put it at a decided disadvantage. In other words, Recommendations 1, 2, 3 and 4 were not met. The CSR was isolated administratively, programmatically and theoretically; it had an impact locally in the greater Cleveland area but not nationally; hence Recommendation 5 was not met. The medical school affiliation has been virtually nonexistent (Recommendation 6). There is no accountability with regard to annual progress reports (Recommendation 7). The theoretical and clinical orientation was limited to one approach; (Recommendation 8). During the past year, the CSR in collaboration with the Mid-Atlantic REMC assumed responsibility for implementing the national training program on PTSD designed by the Special Committee; in that respect it partially met Recommendation 10. Recommendation 11 was met since the CSR functioned as a Specialized Inpatient Unit, however, the patient care mission has taken precedent over research priorities since there have been no systematic studies, no application for Merit Review funding and no emphasis on obtaining research support.

Conclusions

1. Since the VA is the agency that serves that vast majority of individuals with PTSD in the United States, it is the appropriate agency to sponsor a National Center for PTSD.

2. The CSR has been unable to meet the Congressional mandate to function as a National Center for PTSD. It has functioned primarily as a regional specialized PTSD clinical program. Its national visibility has been limited to educational activities.

3. It appears unlikely that the resources, administrative structure, professional staff, university affiliation, theoretical orientation or academic commitment of the CSR can be transformed into a National Center for PTSD in the foreseeable future.

4. In order to succeed, a National Center for PTSD must be established within the kind of framework defined by the Special Committee's eleven recommendations.

Testimony on S.2462

Veterans Administration Health Care Personnel and Program Act of 1988

by Fred Gusman, MSW

Member of the Chief Medical Director's Special Committee on Post
Traumatic Stress Disorder (VACO)

Director of the Specialized Treatment Center for Post Traumatic
Stress Disorder
Menlo Park Division, Palo Alto VAMC

July 14, 1988

Testimony

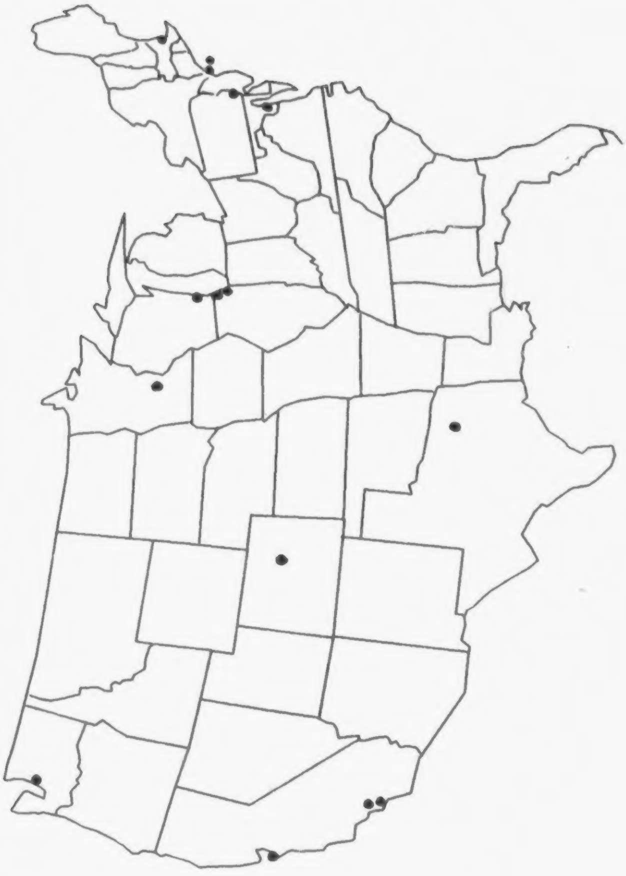
In 1984, the 98th Congress of the United States of America, passed Public Law 90-528, directing the Veterans Administration to establish a special committee of experts in the field of Post Traumatic Stress Disorder (PTSD). This committee, to be known as the Chief Medical Director's Committee on PTSD, is to provide guidance to the Veterans Administration, through the Chief Medical Director (VA Central Office), on the Veterans Administration's ability to provide services for PTSD to veterans of all wars eligible for health care.

The Special Committee on PTSD has been charged with numerous assessment activities related to the delivery of services to the veteran suffering from PTSD.

I, Fred Gusman, M.S.W., a Member of the Chief Medical Director's Committee on PTSD, wish to submit the following testimony at the request of the United States Senate Committee on Veterans Affairs. This testimony focuses upon two areas:

* the Specialized Treatment Teams on PTSD initiated by the Veterans Administration Central Office (VACO)
* the Specialized Treatment Units for PTSD

PTSD Treatment Teams



I. The Specialized Treatment Teams for PTSD Initiated by the Veterans Administration

1. On January 7, 1987 the Veterans Administration Central Office, identified fifteen (15) Medical Centers who were offered the opportunity to initiate Post Traumatic Stress Disorder (PTSD) Treatment Teams for the purpose of addressing the underserved population of veterans suffering from PTSD. The type of services to be provided by these teams would vary dependent upon the PTSD population needs at their designated Medical Center. Variations may include assessment, treatment, inpatient/outpatient consultation, and educational activities. The PTSD Treatment Teams would include a psychiatrist and three other qualified clinicians. Funding for the psychiatrist and one GS 12/5 clinician would be provided by Central Office with the monies for these positions recurring. The designated Medical Centers would provide FTEE and funding for the remaining two members of the PTSD Treatment team as per an agreement in accepting the start-up positions and money from Central Office.

PTSD TREATMENT TEAMS

2. The following VAMC's agreed to provide additional FTEE and monies to establish PTSD Treatment Teams:

a. Minneapolis
b. Dallas
c. Seattle
d. Boston
e. Brooklyn
f. Chicago-Westside
g. New York (Manhattan)
h. Hines
i. Washington D.C.
j. Philadelphia
k. Long Beach
l. Denver
m. San Francisco
n. West Los Angeles
o. Allen Park

3. Each designated VAMC also would be required to submit quarterly reports to VACO as to program development progress.

4. Dr. Matthew J. Friedman, M.D., Ph.D., Chairman of CMD's Special Committee on PTSD, provided an overview in his written testimony (July 14, 1985) on the history and concerns of the Special Committee in relationship to the progress of existing designated PTSD Treatment Teams, and the designation of future PTSD Treatment Teams.

5. Areas of concern in reference to PTSD Treatment Teams are:

a. The methodology for monitoring the activities of PTSD Treatment Teams.

b. The process of selection of future PTSD Treatment Team sites.

c. The timetable for implementation of the Five Year phase-in of establishing PTSD Treatment Teams throughout the VAMC.

6. The CMD's Special Committee on PTSD has, for the last 14 months, attempted to provide consultation and monitor development of the 15 PTSD Treatment Teams. On August 20, 1987, the Special Committee requested initial start-up data from the 15 VAMC's as to their progress in establishing PTSD service by their respective teams. In March 1988 this data was updated. The Data collected concerns the following areas:

a. The process in developing the PTSD Treatment services to be provided

b. The individuals who participated in the Development process

c. The PTSD Treatment Team's goals and objectives

d. The data or variables that guided the planner in defining the PTSD Treatment Team's goals, objectives, and services to be provided.

e. The date of the implementation of the PTSD Treatment Team and the utilization of FTEE allocated to the designated VAMC

f. The obstacles in implementing PTSD Treatment Teams, ie., defficiency in filling positions, waiting for environmental space, etc.

g. (1) Identification of individuals who have been selected to fill FTEE alloted to the medical center

(2) Identification of FTEE that the designated medical center has provided to augment the two FTEE allocated by VACO

h. The number of veterans provided service by the designated PTSD Treatment Teams

i. The types of services that were provided to these veterans

j. The percentage of veterans seen that carry a co-diagnosis

k. The breakdown in prevalence of the co-diagnosis by the PTSD Treatment Teams

l. The description of follow-up services being provided by the PTSD Treatment Teams

m. The extent of collaboration with Vet Centers

n. Outcome data or plans to collect outcome data

o. The development and type of research that the PTSD Treatment Teams have initiated, are participating in presently, or will participate in the immediate future

p. The description of an educational component of the

q. The description of a quality assurance mechanism to insure a high level of service

r. The methods in identifying the level of efficiency in services the PTSD Treatment Team is providing

Summary

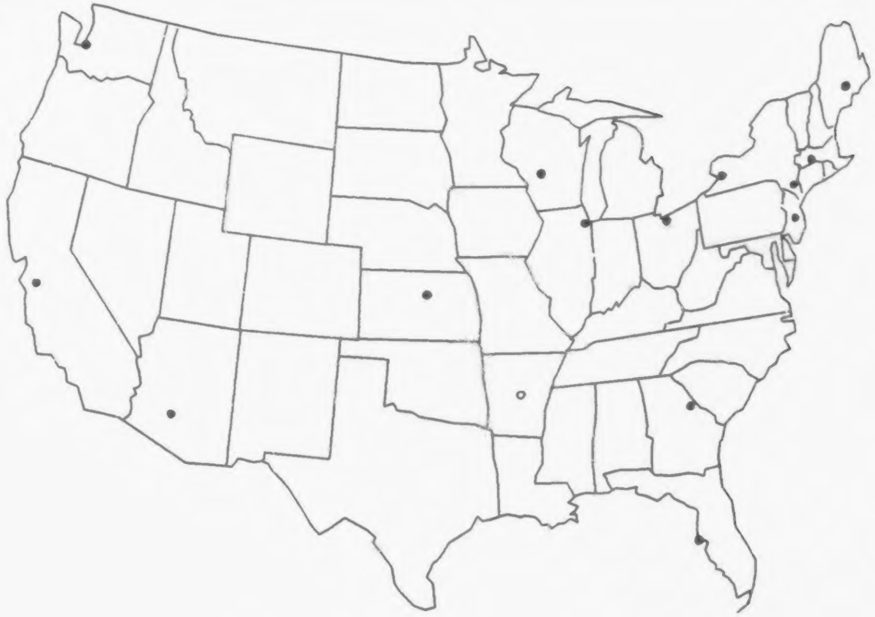
The Special Committee recognizes the efforts of the CMD and the Department of Mental Health and Behavioral Sciences in initiating the PTSD Treatment Teams.

The aforementioned data that the Special Committee has collected is presently being analyzed and prepared for the next Annual Report by the Special Committee on PTSD.

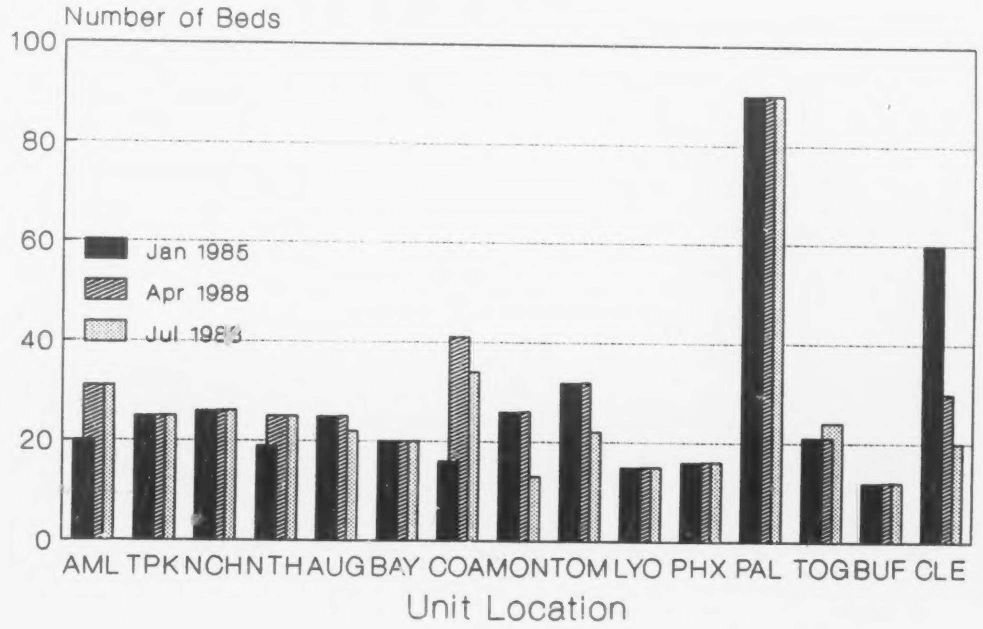
The preliminary findings indicate variability between PTSD Treatment Teams.

Should the term of the CMD Special Committee be extended beyond 1989, the Special Committee would continue to offer evaluation and recommendations to VACO on the development of present and future PTSD Treatment Teams.

Specialized Inpatient Programs for PTSD



Specialized Inpatient Units
Bed Capacity



VACO Designated Inpatient Treatment Programs for Post Traumatic Stress Disorder

* Ten (10) Veteran Administration Medical Centers had established in-patient treatment programs for Post Traumatic Stress Disorder (PTSD) prior to 1984. The Palo Alto VAMC, Menlo Park Division was the first program, established in January, 1978. Other VAMC programs established for inpatient PTSD prior to 1984 included Bay Pines, Northhampton, North Chicago, Topeka, Coatesville, Augusta, Montrose, and Lyons.

* All ten (10) inpatient treatment units were funded out of the hosting Medical Center's budget.

* The Special Committee on PTSD has no knowledge of these self initiated inpatient treatment programs being fiscally supported by either the Region or VACO prior to 1984.

* Following the Hearing before the Subcommittee on Hospital and Health Care, of the Committee on Veterans Affairs, in the House of Representatives on March 29, 1984, VACO allocated seventy (70) FTEE and Salary Dollars, averaging approximately $34,611.50 per FTEE. The majority of the FTEE and salary dollars were allocated to the Center for Stress Recovery, Cleveland, Ohio. Two (2) other VA Medical Centers, American Lake and Phoeniz, were authorized FTEE and salaries to initiate programs. VACO had also augmented existing staffing of some of the self-initiated PTSD programs.

* The number of beds in these programs varied from sixteen (16) to ninety (90).

* Staffing of the programs varied from twenty-four (24) hour coverage with a multidisciplinary staff to minimum staffing and the inability to provide the multiple services required for a comprehensive treatment program, i.e. Vocational Rehabilitation, Employment counseling, Housing and alternative community support networks.

* Bed occupation rates also varied dependent upon the program structure and staffing.

* The majority of these programs were attempting to provide initial screening for inpatient treatment and in a few instances outpatient follow-up.

* Many of the programs had established a waiting list for admission screening plus a waiting list for admissions. Veterans in some geographical areas could possibly wait from three (3) to six (6) months before being screened or admitted to an Inpatient PTSD Treatment Program.

* Program structure, philosophy of treatment, clinical expertise in the area of PTSD, administrative support and guidance, all varied tremendously from program to program. At a few of the Medical Centers that hosted inpatient treatment programs for PTSD, the Special Committee noted the support of the Medical Center in setting the treatment of veterans with PTSD as one of their top priorities. These few programs that enjoyed such a committee by the Medical Center, were clearly developing into high quality Inpatient Treatment Programs for PTSD.

* The Special Committee on PTSD was unable to establish VACO and VA Regional Office involvement in development of operational guidelines or quality assurance standards specifically addressing inpatient treatment for PTSD as a specialty.

* Summary - The Special Committee on PTSD, after reviewing the data provided in the first Annual Report of January 25, 1985, set as a priority the monitoring of Inpatient Treatment Programs for PTSD, to include on site evaluation prior to submitting the Special Committee's Annual Report for 1986.

The Special Committee was able to meet with representatives from all thirteen (13) existing PTSD programs in May, 1985 at the first National Training for Inpatient PTSD Treatment Units, sponsored by VACO and the Mid-Atlantic RMEC, Cleveland, Ohio. This national meeting was followed up with site visits by the Special Committee to six (6) of the existing thirteen (13) programs, as well as, the on-going monitoring of these programs through formal and informal methods.

In Chapter 3 of the 1986, Special Committee Annual Report, numerous findings were discussed with recommendations made in the following areas:

a. Quality Assurance
b. Program planning and design
c. Length of Stay
d. Admission criteria
e. Treatment standards
f. Staff preparation
g. Administrative funding concerns - outcome studies and geographical distribution

The Chief Medical Director's office, through the Department of Mental Health and Behavioral Science, and the Department of Academic Affairs, has begun to address the continual need for education for the Inpatient Treatment Programs.

The Department of Mental Health and Behavioral Science has also begun to develop a guide for General Psychiatric Units who treat veterans with PTSD as well as a guide for Inpatient PTSD Treatment Programs.

Although the Department of Mental Health and Behavioral Science has demonstrated a more active posture than prior to 1984, the Inpatient PTSD Treatment Programs can be classified in three ways:

1. Problematic of uneven quality
2. Adequate standards of care
3. Recognized centers of excellence

The Special Committee on PTSD continues to monitor the Inpatient Treatment Programs for PTSD. Data has been collected in the following areas:

* Program development and philosophy
* Bed authorization
* Bed census
* Admission criteria
* Diagnostic and psychometric measurement for assessment
* Staffing
* Administrative support
* Waiting lists
* Program length
* Community/Vet Center/Program relationships
* Outcome studies and research

More recent areas, such as, beneficiary travel, direct and indirect influences of the Resource Allocation Methodology (RAM) are reported to the Committee.

The Special Committee has begun to analyze this data and is now in the process of preparing to incorporate these findings with recommendations into the next annual report.

Preliminary analysis of the data has been shared with the Department of Mental Health and Behavioral Science prior to this testimony. The Special Committee feels strongly that a fair portion of the difficulties that continue to plague the Inpatient Treatment Programs for PTSD require intervention not only at the local level, but also the Region and VA Central Office levels.

The aforementioned comments are based not on subjective impressions of inpatient data, but on three and a half ($3^1/_2$) years of the Special Committee's exhaustive data collection supported by hundreds of contacts with the field, from Medical Center Directors to the hands on Clinicians. Interfacing with the veteran who suffers PTSD is a never ending process. For those attempting to provide psychiatric service to a population whose need and right to treatment is still questioned, it is even more difficult.

The future of Inpatient Treatment Programs for PTSD requires immediate attention. Leaders in the field of treatment and research of PTSD have acknowledged how the chronic PTSD population is growing in numbers. Recent papers presented at the Society for Traumatic Studies in Baltimore, Maryland in 1987, as well as data collected by Inpatient PTSD Programs, Vet Centers, Mental Hygiene Clinics, all indicate a high proportion of veterans seen for PTSD also having another diagnosis. Diagnoses reported with PTSD include Alcoholism, other substance abuse, depression, family/marital discord, learning disabilities, chronic medical problems such as, hypertension, diabetes, orthopedic degenerative problems and various neurological disturbances.

Inpatient treatment programs are not necessary for every veteran suffering from PTSD. The majority of veterans with PTSD are being treated in outpatient settings such as Vet Centers or Mental Hygiene Clinics. It is not the Special Committee's intention to homogenize PTSD inpatient treatment programs to the extent that creativity in treatment, research, and education is hampered.

The Special Committee does believe that when a veteran suffering from PTSD is in fact of danger to himself or others, and outpatient resources are no longer able to support him outside the hospital, then the veteran must be able to access inpatient treatment. In some cases, a short hospitalization in a general psychiatric inpatient setting or substance abuse setting may suffice. In most cases however, the veteran with PTSD is in need of an Inpatient Treatment Program. Therefore, obstacles such as geographical distance, waiting lists, beneficiary travel, length of stay, or funding of the program must be corrected so no veteran is prevented from receiving the best possible care the VA system can provide.

This government created the Veterans Administration with one purpose being to provide health care for the veteran who served in the military and as a result of his/her service, suffers a war related health problem. Post Traumatic Stress Disorder should therefore be considered a priority that this Country,Congress, and Veterans Administration devotes the appropriate resource and time necessary to assist veterans suffering from Post Traumatic Stress Disorder.

It is laudable that the Veterans Administration through Congress has continued to take on new health problem areas such as AIDS and the HOMELESS. However, at a time when Congress and its agencies like the Veterans Administration are asked to re-evaluate their priorities and budgets, PTSD must be remembered. It is imperative and morally correct that Congress and the Veterans Administration recognize and fulfill their obligation to the veteran who gave of himself. The veteran suffering from PTSD, in the heat of battle,did not have the luxury to declare a time out while engaging the stressors of war. The veteran has served in good faith that the government and its agencies would fulfill its commitment. Chronic PTSD is unrelenting and increasing in complexity as years pass.

The responsibility of treatment for PTSD is not solely the burden of the VA. Should Congress request the VA to increase services for PTSD veterans, without appropriate funding, positions for treatment, as well as allocated monies and FTEE to manage these services, a travesty and a continuation of waivering commitment will act to exacerbate the veterans repatriation process. This concludes the written testimony concerning the current status of the designated Inpatient Treatment Programs for PTSD as found by the Chief Medical Director's Special Committee on PTSD.

Testimony on S.2462

Veterans Administration Health Care Personnel and Program Act of 1988

by

Fred Gusman, MSW

Director of the Specialized Treatment Center for Post Traumatic Stress Disorder
Menlo Park Division, Palo Alto VAMC

July 14, 1988

The Menlo Park Inpatient Treatment Program for PTSD : A Ten - Year Evolution

Mr. Chairman and Committee members, the Palo Alto VAMC has a long history of initiating health care programs that eventually evolve into centers of excellence.

I, Fred Gusman, M.S.W., Director of the Specialized Treatment Program for Post Traumatic Stress Disorder (PTSD) at the Menlo Park Division of the Palo Alto VAMC, am here at the request of the Committee on Veterans Affairs today, July 14, 1988 to share the history and the accomplishments of our nationally recognized treatment center for P.T.S.D.

When I testified before Congress on March 29, 1984, I focused on the early development of our inpatient treatment program. As I stated in that testimony, the Menlo Park program evolved through an identified need which was not being met. A psychiatric program that could address the psychological and social disruption in the lives of combat veterans had not yet been developed at this Medical Center.

Dr. Mark P. Graeber, Chief of Staff, Menlo Park Division took a keen interest and the leadership role in stimulating the Medical Center staff in a responsive approach to program development. Upon his initiation of a Medical Center wide, Multidisciplinary committee, the Menlo Park P.T.S.D. Program was born.

In our ten - year history, this program has provided not only treatment for thousands of veterans from all parts of the country but has also taken a leadership role in consultation and education in the area of P.T.S.D. treatment. This has included over hundreds of formal consultations, sight visits, as well as being host to clinical and academic visitors to the Menlo Park program.

This center was the focus of a formal evaluation by the CMD's Special Committee on P.T.S.D. After direct observation of group intervention, discussions with patients, and experience with the social milieu, the Committee found the program to be of the highest quality.

The Department of Mental Health and Behavioral Sciences, Veterans Administration Central Office, has also informally recognized our treatment efforts by directing other Medical Center staff and individual clinicians to this program for assistance in program development.

Origins of Success in the Oldest and Largest Treatment Center for PTSD

To what do we attribute our continuing success in treating the veteran of combat trauma? Beyond the background factors and uniqueness of our Medical Center which have been described in my 1984 testimony to Congress, I would add the following three areas:

1) Maintenance of a patient-focus in the evolution of a multi-modal approach to comprehensive treatment;

2) An egalitarian managment system and strong administrative ties;

3) Close patient tracking, active program evaluation, and a vigorously developing Research Component.

Patient-focus and Multi-Modal Approach to Treatment

It is not uncommon to see a number of schools of thought or treatment approaches vie for prominence in psychiatry. However, singularity of approach to the combat veteran appears to be inadequate. It became clear that a focus upon individual patient need became a guiding principle in the delivery of services in our program. In attending to his suffering first and foremost, the flexibility in approach was fostered and blossomed into the current multi-modal approach to comprehensive treatment.

The therapeutic community, a social psychiatry model originating in Great Britain, has become the powerful backdrop to the various interventions within the program. It permits the development of strong cohesion among the patients, development of an ethic of commitment to change, and a regulating force against impulsive or aggressive behavior. Beyond the overall social milieu, however, staff interventions draw from a number of orientations in psychiatry, clinical and cognitive psychology. Their utility has largely been determined by staying abreast of the research in PTSD; information exchange with other leaders in the treament of the disorder; results of our own program evaluation and outcome; and our own contantly developing expertise with the disorder.

Egalitarian Program Management and Adminisistrative Ties

Since the program's inception, all staff members are involved in a quarterly program review in which the successes and shortcomings of the treatment offered are evaluated. Modifications to the program can originate from any staff member and consensus on the new program is obtained over the course of a one to two week period. This egalitarian program review is another powerful source of innovation in treatment and has helped maintain a deep sense of commitment to the therapy by our medical and clinical personnel.

A number of lines of communication have also been maintained with the administrative staff of the Palo Alto VA Medical Center. This has created an atmosphere of support with far reaching vision for the program. Methods of contact include: weekly meetings with the Inpatient Unit Psychiatry Chief; weekly meetings with the Liaison to the Chief of Staff; monthly briefings with other Service Chiefs; and ongoing formal and informal contact with all Service Chiefs, the Chief of Staff, and the Hospital Director. An intimate administrative awareness of the program's activities has thus broadened the levels of commitment to excellence in clinical care to the traumatized veteran.

Patient Monitoring and the Research Component

A longstanding reliance upon the advantages of high technology has been in effect at the Menlo Park PTSD Unit. In 1985, Dr. Vitali Rozynko, Staff Psychologist, instituted a microcomputer based spreadsheet program which generated a current patient roster including admission date, length of stay, and the specific treatment groups they were attending. As the "clinical cornerstone" for all staff meetings, this database allowed direct tracking of a large number of patients by every staff person.

In the last year, Dr. Harvey Dondershine, Senior Psychiatrist, has further elaborated upon the database to increase its power and clinical utility. Psychiatric and medical problem areas unique to each patient, projected discharge date, self-reported obstacles to therapy have all been included. Moreover, individual patient summaries can automatically be generated for periodic treatment reviews and in preparation for their transition to the community. Substantial savings in staff time as well as greater consistency in the quality of care through timely, accurate updates has been realized with this patient tracking system.

In the spirit of increasing the objectivity of the program evaluation, a Research Component was established in 1986 when Research Clinical Psychologist, Dr. Francis R. Abueg, was brought on board. Dr. Abueg first assisted the program in outcome evaluation by increasing the rigor of psychometric evaluation upon patients' exit from the program, as well as instituting a formal ongoing followup project.

Second, he designed a study documenting the diagnostic complexity of our patient population which was presented at a national conference on trauamtic stress last October (Abueg, Rozynko, Gusman, & Flint, 1987). It was this study that helped to substantiate, in a large sample of inpatient veterans, the co-occurrence of other psychiatric disorders appearing in conjunction with PTSD. Most important to the conduct of our program was that 42% of 350 patients received an active diagnosis of alcohol dependence or abuse.

Third, the Research component has incorporated these data into experimental attempts at treating the dual diagnosis of P.T.S.D. and Alcoholism. These initial attempts have been sufficiently encouraging to warrant submission of a grant proposal to formally evaluate outcome of novel approaches combining the two areas. The Far West Regional Field Program of the Health Systems Research and Development (HSR&D) has funded this project which is currently underway. Moreover, in response to the demand for services in this area, we have apportioned twenty-eight (28) of the ninety (90) beds to a Dual Diagnosis service based upon the most recent advances in both areas of Alcohol and P.T.S.D. research.

Finally, due to the quality and size of the Menlo Park P.T.S.D. program of the Palo Alto VAMC and the vigor of the Research component, we have chosen to participate in the design of a national cooperative study of the psychophysiological aspects of P.T.S.D in Vietnam veterans in the VA, chaired by Dr. Terence M. Keane, a prolific and respected reaearcher in the area of combat stress.

We have been recognized for our numerous clinical contributions and in recent years for our growing role in research in P.T.S.D. However, we believe that a P.T.S.D. Center for Excellence relies upon an interaction of variables: substantive and efficacious treatment, high quality personnel, a flexible and egalitarian management style, strong administrative ties through all levels of the VA system, and a nonstagnating vision which uses responsivity to patient needs as its guide.

As a matter of public record, we are happy to continue to share our expertise and a leadership role in program development, treatment, and education.

In closing, I would like to acknowledge, Mr.James DeNiro, Medical Center Director, Palo Alto Veterans Administration; Dr. Mark P. Graeber, Chief of Staff, Menlo Park Division; Dr. William Van Stone, Assistant Chief of Staff; John Wax, L.C.S.W., Chief of Social Work Service; Stephen Berman, AA/COS Menlo Park Division; Alice Naqvi, RN Assistant Chief of Nursing, Menlo Park Division; Robert Ely, PhD, Assistant Chief of Psychology; and Mr. Richard Lindsey, Region 6, Regional Director for their continued consultation and support. I also wish to thank Francis Abueg, PhD, Tracy Dekelboum,MSW, and Kathy Lockhart, RN,MSN, for their assistance in preparing this testimony.

I would like to take this opportunity to thank the Committee on Veterans Affairs for inviting me to testify concerning the Menlo Park Division, Specialized Treatment Center for Post Traumatic Stress Disorder.

APPENDIX

The following is a representative sampling of the broad range of community, regional, and national activities which the Menlo Park program has either initiated or participated in:

National Activities: Staff Participation

National Vietnam Veterans Readjustment Study, Consultation for Validation Study, 1985.

National VA Cooperative Study on the Psychophysiology of PTSD in Vietnam Veterans, Participating Investigator, Current - 1988.

Membership, CMD Special Committee on PTSD - Fall, 1984 - present.

National Training on Treatment of PTSD - Faculty 1985 - present, sponsored by Academic Affairs, Mental Health and Behavioral Science, and RMEC.

Program Development Consultative Services for American Lake, Topeka, Augusta, Phoenix, Northamptom, Bay Pines, Montrose, Lyons, and Togus.

Regional Education Program Faculty for Readjustment Counseling Training - Regions 6,5,4,3.

Community Activities: Patient Participation

Year long patient volunteer involvement with the Special needs program for Developmentally Disabled Children, San Carlos, California. 1986 - present.

Patient volunteers to monitor "Red Ribbon - Just Say No to Drugs Parade", City of San Mateo, California. 1987

Patient volunteers restored a children's playground for Nealon Park, Menlo Park, California.

PTSD Program Choral Group - Fifty member choir from the program participating in various community functions and activities throughout California. In 1981 - 1982 sang during the National Vietnam Veteran Recognition Week and Dedication of the Memorial in Washington, D.C.

Annual participation of the PTSD Program in the largest 4th of July parade in the State of California. Redwood City, California.

Medical Center
3801 Miranda Avenue
Palo Alto CA 94304

Veterans
Administration

In Reply Refer To:
640/323D

July 21, 1988

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Senator Cranston:

I am providing you with an overview of our dual diagnosis program, PTSD and Alcoholism, as you requested on July 14, 1988, at the oversight hearings on post-traumatic stress disorder.

Please feel free to contact me should you require further clarification.

Sincerely yours,

Fred Gusman

FRED D. GUSMAN, M.S.W.
Director, PTSD Center
Menlo Park Division

cc: Mental Health & Behavioral Sciences Service
VA Central Office

PTSD-ALCOHOLISM AND THE MENLO PARK PTSD TREATMENT CENTER

Recent results released by the Centers for Disease Control and the Research Triangle Institute have confirmed that a high percentage of Vietnam combat veterans suffer not only from severe chronic anxiety but also from substance abuse and dependence. More specifically, alcoholism has been estimated to afflict between 40% and 80% of Vietnam veterans with post-traumatic stress disorder (PTSD).

Clinicians and researchers working with Vietnam-related PTSD are not surprised by these findings. It has been repeatedly observed that PTSD and alcoholism interact in an insidious way: flashbacks, hyperreactivity, sleep disturbance and guilt place the veteran at extreme risk to "self-medicate" with alcohol. Conversely, chronic alcohol abuse heightens depression, isolation and guilt. Breaking the cycle becomes a formidable challenge to health care providers especially in the many cases where the interaction has developed and worsened over a twenty-year period.

A number of reports have already drawn attention to substance abuse among Vietnam veterans (Boscarino, 1980; Blum, Kelly, Meyer, Carlson, & Hodgson, 1984), and those with PTSD (Sierles, Chen, McFarland, & Taylor, 1983; Lindy, Grace, & Green, 1984) but documented treatment efforts have been rather limited (e.g., Kuhne, Nohner, & Baraga, 1986; Schnitt & Nocks, 1984).

This is not to say that the problem of alcoholism and PTSD in combination has gone unattended. We are aware of a number of grass roots attempts at treating PTSD-alcoholics at VA Medical Centers (see Reaves, Atkinson, Kofoed, et al. 1988 for an example) and Vet Centers. However, these efforts are still extremely limited in scope. Moreover, no scientific treatment outcome studies have been reported with this population. With the encouragement of our medical center administration and funding from HSR&D, the Menlo Park PTSD Treatment Center of the Palo Alto VAMC has marshaled a plan combining both immediate service delivery to this needy population and formal outcome research.

1. Recognition of Need. As I had testified last week, we conducted a survey of co-diagnoses among our inpatient veterans at Menlo Park. In a sample of 350, 42% were found to meet the criteria for alcohol abuse or dependence (Abueg, Rozynko, Gusman, & Flint, 1987). Some differences in the manifestation of psychological symptoms were noted between alcoholic-PTSD and nonalcoholic PTSD patients--higher dependency in the first group, for example--and appear to warrant further study.

We and other health care providers in the VA have been aware of another problem: the often limited alliance between Drug and Alcohol Units and PTSD Units. The veteran suffering from both disorders has often "fallen between the cracks" of those two services. Beyond sheer numbers of patients in need, linking of clinical expertise appears to be another unmet need.

2. Conceptual Foundation for Treating PTSD-Alcoholics. Dr. G. Alan Marlatt of the University of Washington has developed one of the most comprehensive models for understanding and treating substance abuse. The Relapse Prevention Model is based upon extensive behavioral research on the addictions along with a special emphasis on maintaining abstinence in the long run. Methods of intervention include anxiety reduction, learning alternative coping responses to drinking urges, identifying "high-risk" for relapse situations, and developing a strong repertoire of refusal skills ("just saying 'No'" is not enough).

Although applying the model directly to the problem of PTSD-alcoholism appears tempting, careful conceptualization of the interaction of the problems was necessary to avoid oversimplification of the patient's difficulties. We were fortunate to have over 10 years' and thousands of patients' worth of experience with combat-related PTSD in addition to the growing knowledge base on trauma. At the very least, the following 3 issues needed attention in the development of a Modified Relapse Prevention Model for PTSD-Alcoholism (Abueg, Kriegler, & Gusman, to be submitted for publication):

a) The PTSD victim's high-risk situations are numerous. Beyond emotional states similar to original traumatic situations of combat (e.g., loss, guilt, disappointment, confusion), the actual symptoms of PTSD--cognitive intrusions, sleep loss, social avoidance--are extremely high-risk cues.

b) Most forms of Vietnam-related PTSD are now considered in their chronic stage (Kolb, 1987). After such a long period of serious psychiatric dysfunction, global decline in coping skills results. Resistance to high-risk situations such as those cited above is consequently quite low.

c) The combat veteran with PTSD has rather severe self-attributions regarding failure. Combat training compels the soldier to acquire the notion that mistakes can be lethal; actual loss of life due to errors only strengthens that belief/expectancy. The psychological "fallout" after a return to drinking appears to be especially severe for the traumatized patient.

These observations and others emanating from the literature on trauma helped to shape not only a way of understanding this patient but also concrete ways of helping him.

3. Pilot Interventions. In response to the demand for services and some careful design, a group addressing the interaction of the problems was implemented in the Menlo Park PTSD Program. In the last 10 months, 44 patients have been treated with a Modified Relapse Prevention (MRP) approach. By the end of each group, all patients show moderate to marked resistance to have a drink in various situations, as measured in an interview and by psychological tests. Since we are limited in our resources and thus unable to offer this treatment to all patients who might benefit, we have the ability to compare outcome on these same measures. With preliminary small sample comparisons, MRP patients show higher relapse resistance than non-MRP patients. Finally, 3-month followup data shows that 14 of 16 patients contacted have reported that they have not returned to drinking nor sought rehospitalization. Data collection continues; a preliminary report will be submitted for publication in a scientific journal shortly.

These data were sufficiently encouraging to lead us to propose a formal outcome study. A grant from the Health Systems Research and Development (HSR&D) Far West Regional Program has been funded and is currently underway.

4. Bed Re-Apportionment to Accommodate Clinical Needs. As of August 25, the Menlo Park PTSD Center will re-assign 28 of its 90 beds to a coordinated PTSD-Alcohol Unit. This change is in direct response to the overwhelming patient need. It should be noted, however, that resources must be borrowed from the balance of the PTSD Center as well as other services within the hospital (e.g., Drug and Alcohol Rehabilitation and Education).

This re-apportionment effort could not have been successfully orchestrated if not for a committed linkage between Psychiatry (the PTSD Center), the Mental Hygiene Clinic, and Drug and Alcohol Rehabilitation. A hospital committee was formed[1] in April 1988 and has formalized an integrated service delivery model which will be conducted within the PTSD Center. Thus, the power of the milieu model will be retained but augmented by group interventions based upon the interactive conceptualization (MRP) described in Item #2.

The details of the program structure are as follows: The patient will have an equivalent length of stay (90 days) but will receive a number of groups addressing alcoholism and/or the interaction with PTSD. Phase I begins with formal psychometric evaluation and a structured clinical interview by a psychiatrist, clinical psychologist or psychology intern. A treatment plan is developed and the patient begins to become a part of the therapeutic community. As with other patients in the PTSD Center, Vietnam is placed in the context of an overall life course so much attention is paid to developmental issues. Commitment to change and taking responsibility for one's behavior are dominant themes of Phase I. Phase II will involve more intensive work with Vietnam traumas ("Focus Group"), learning the basics of recovery from alcohol use if that is unfamiliar to the patient, formal involvement with local AA groups, Modified Relapse Prevention (MRP), and more specific problem groups when indicated (depression, Adult Children of Alcoholics, anger).

Phase III, again consistent with the PTSD program proper, involves the activation of transition plans, job skills development, and community or family exposure. Here the linkage with and active involvement of DARU and MHC permits close tracking of these patients with high recidivism rates.

Staffing includes a multidisciplinary team: 1 psychiatrist, 1 clinical psychologist, 1 clinical social worker, around-the-clock nursing coverage (8.5 R.N.'s and 10 other nursing staff), 1/3 nurse practitioner, 1/3 occupational therapist, 1/3 social worker, 1/3 family therapist and 1/3 educational/art therapist.

---

[1] Hospital Planning Committee on PTSD-Alcohol Membership:
Fred Gusman, M.S.W., Director, PTSD Center
Francis Abueg, Ph.D., Coordinator of Research, PTSD Center
Micky Indianer, D.O., Psychiatrist/Asst. Chief, DARU
Daniel Walz, M.S.W., Director, MHC
Erika Curran, M.S.W., Family Specialist
Jackie Wenner, M.S.W., Social Work Service

References

Abueg, F. R. (1988). *Unpublished raw followup data on patients discharged from the Specialized Inpatient Unit for Post-Traumatic Stress Disorder (PTSD).* Available from author, Psychology 116B1 (MPD), Palo Alto VAMC.

Abueg, F. R., Kriegler, J., & Gusman, F. D. (to be submitted). Preliminary outcome data on Modified Relapse Prevention with PTSD-alcoholics.

Abueg, F. R., Rozynko, V., Gusman, F. D., & Flint, G. (1987). *Mixed diagnosticity in combat-related post-traumatic stress disorder.* Paper presented at the Annual Meeting of the Society for Traumatic Stress Studies, October, Baltimore.

Boscarino, J. (1980). Current excessive drinking among Vietnam veterans: a comparison with other veterans and nonveterans. *International Journal of Social Psychiatry*, *27*, 204-212.

Blum, M. D., Kelly, E. M., Meyer, M., Carlson, & Hodgson, (1984). An assessment of the treatment needs of Vietnam-era veterans. *Hospital and Community Psychiatry*, *35*, 691-696.

Brown, T. A., Abueg, F. R., & Fairbank, J. A. (in press). Psychological patterns of response to trauma. In L. Gibbs et al. (Eds.), *Community Psychology: Second Edition.* NY: Guilford Press.

Kolb, L. (1987). *Status of Vietnam-related post-traumatic stress disorder (PTSD).* Invited address at the Northeast Regional Medical Education Center Conference on PTSD, November, Northport, New York.

Reaves, M. E., Atkinson, R. M., Kofoed, L. L., et al. (1988). Mental health services for Vietnam veterans. *VA Practitioner*, *5*, 15.

Sierles, F. S., Chen, J., McFarland, R. E., & Taylor, M. A. (1983). Post-traumatic stress disorder and concurrent psychiatric illness: a preliminary report. *American Journal of Psychiatry*, *140*, 1177-1179.

Veterans
Administration

Memorandum

Date July 19, 1988

From Joan A. Furey, R.N. M.A.
Member, Chief Medical Directors Special Committee on P.T.S.D.
National P.T.S.D. Training Program

To Chairman, Senate Veterans Affairs Committee

1. The C.M.D.'s Special Committee on P.T.S.D. recommended in its 1985 report that the Veterans Administration undertake a coordinated systematic approach to P.T.S.D. education and establish a National Training Program. Subsequent recommendations suggested that emphasis be placed on presenting programs to focused groups of personnel that would significantly impact the assessment and treatment of P.T.S.D. throughout the Veterans Administration. Those groups included:

A. Chiefs of Clinical Services
B. V.A.M.C.'s with low rates of P.T.S.D. diagnosis
C. Direct care providers
D. Specialized Inpatient Treatment Programs
E. Non-Psychiatric Health Care Providers
G. DM&S Examiners and Physicians on DVB Adjudication boards.

2. Working in conjunction with representatives of the Special Committee, Academic Affairs, Mid Atlantic RMEC, Readjustment Counseling and the Department of Veterans Benefits; Mental Health and Behavioral Services has coordinated the following programs since our initial report.

A. National:
    1. Specialized P.T.S.D. treatment units
       May 1985, Brecksville, Ohio
       Sept. 1987, Northport, N.Y.
    2. Second National Hispanic Conference on P.T.S.D.
       Sept. 1987, San Juan, Puerto Rico

B. Regional:
    1. Chiefs of Psychiatry, Psychology, Social Work, Nursing and D.V.B staff and Vet Center staff (ink) Region II FY '86 (J.K.)
       a) Region I 'F.Y.'85
       b) Region IV 'F.Y.'85
       c) Region I 'F.Y.'86
       d) Region V 'F.Y.'86
       e) Region VI 'F.Y.'86
       f) Region III 'F.Y.'87
       g) Region VII 'F.Y.'87
    2. Counseling the Vietnam Veteran: Multidisciplinary
       Region III - Regional Teleconference 1/88.

C. District: Multidisciplinary Health Care Professionals
1. Diagnosis and Treatment of P.T.S.D.
   Baltimore, Maryland 9/86
2. Differential Diagnosis of P.T.S.D.
   Minneappolis, Minnesota 9/86
3. Assessment & Treatment of P.T.S.D.
   Detroit, Michigan 9/86
4. Therapeutic Management of Anger in P.T.S.D. patients
   Romulus, Michigan 6/87
5. The Stress Response Syndrome
   Salt Lake City, Utah 9/87
6. Concurrent Diagnosis and Treatment of P.T.S.D.
   and Substance Abuse
   Phoenix, Arizona 9/87

3. The following programs are planned for implementation in the coming months

A. National:
1. P.T.S.D. Treatment Teams - Location: TBA 9/88
2. Training Module for C&P Physicians
   Videotape development planned for F.Y.'89.

B. Regional*: Non Psychiatric Health Care Providers
1. Counseling the Vietnam Veteran - Teleconference

a) Region 5,6,7,	8/4/88
b) Region 4,5	9/1/88
c) Region 4,5,7	9/6/88
d) Region 1,2,	9/8/88
e) Region 1,4	9/9/88

*These teleconferences will cover Districts 1-7, and 12-27. The Region III teleconference held in Jan of 1988 covered the remaining districts.

4. Following the completion of these programs the primary groups identified for educational activities in the 1986 report will all have been addressed.

5. The Special Committees' Recommendations for future National Education activities are:
   a) Continued emphasis on those medical centers with unusally low diagnostic activity in P.T.S.D.
   b) P.T.S.D. Treatment Teams
   c) Substance Abuse Treatment providers
   d) D.V.B. personnel including C&P physicians and adjudicators
   e) Focused presentations on the assessment, diagnosis and treatment of P.T.S.D. in minority groups, including women.
   f) Concurrent Diagnosis and treatment of P.T.S.D. and Substance Abuse

Respectfully submitted,

JOAN A. FUREY, R.N., M.A.

TESTIMONY ON VA OVERSIGHT HEARINGS BEFORE U.S. SENATE COMMITTEE ON VETERANS AFFAIRS,

JULY 14, 1988

BY

RAYMOND M. SCURFIELD, D.S.W.

DIRECTOR, POST-TRAUMATIC STRESS TREATMENT PROGRAM

AMERICAN LAKE V.A. MEDICAL CENTER, TACOMA, WASHINGTON

Firstly, I would like to express my appreciation for being requested to testify today before this Oversight Hearing on the Veterans Administration and its efforts regarding Post-Traumatic Stress Disorder (PTSD). Before going any further, I want to mention that by being here, I am missing another very important event that happens to be taking place this afternoon -- the graduation ceremony of the 26th group of war-veterans to complete our intensive 11-week inpatient PTST Program. Since I cannot be there in person to hand out the graduation certificates, I would like to enter for the record my acknowledgement and congratulations to these 10 vets who are completing "Phase I" (eg, our 11-week inpatient program) of their stress recovery. Six of these vets are from Western Washington State and one each from Eastern Washington, Oregon, Montana and Hawaii. As it is printed on our graduation certificates, these veterans are being honored today for "completing the 11-week program and in rememberance and appreciation for service to our country, your accomplishments past and present, and our belief in your potential".

I understand my testimony is to focus on my experiences in establishing and directing one of the more recently implemented VA designated inpatient PTSD programs, the American Lake (Tacoma) Post-Traumatic Stress Treatment (PTST) Program. However, because of my background with the Vet Center Program (National Associate Director for Clinical Services, 1982-85), as Chief of a VAMC-based innovative outpatient program for Vietnam veterans (the Vietnam Veterans Liaison Unit, West Los Angeles VAMC, 1979-82), and as the psychiatric social work and executive officer on one of the two U.S. Army psychiatric teams in Vietnam (98th Medical Detachment, 8th Field Hospital, Nha Trang, 1968-69), I will at times make comments about the larger picture of PTSD and the Veterans Administration.

My testimony is organized into the following sections: (1) a brief description of PTSD; (2) the intensive inpatient treatment strategy and rationale for chronic, severe PTSD treatment; (3) the program structure and design of the ALVAMC PTST Program; (4) preliminary results of a follow-up study of 180 ALVAMC PTST program graduates; factors that are (5) impediments or obstacles and that are (6) conducive or positive, to establishment and operation of a designated PTSD unit; and (7) other considerations.

POST-TRAUMATIC STRESS DISORDER

The preliminary report by the Research Triangle Institute on the National Vietnam Veterans Readjustment Study undoubtedly provides substantial descriptive data about the range and extent of "readjustment problems" among Vietnam-era veterans. However, I would like to briefly highlight some relevant factors. Firstly, the official categories of PTSD symptoms include: (1) recurrent, intrusive symptoms (such as psychologically reexperiencing aspects of the trauma through dreams, thoughts and in extreme cases, through dissociative reactions); (2) avoidance or numbing symptoms (such as efforts to avoid thoughts, feelings or symbolic activities or situations, diminished interest in significant activities, and isolation); and (3) increased arousal symptoms (such as difficulty falling or staying asleep, irritability or anger outbursts, hypervigilence, and exaggerated startle response). There are additional accompanying symptoms generally recognized as part of the PTSD symptom picture, to include seriously impaired and negative self-esteem, self-destructive or self-defeating behaviors, survivor guilt and alienation.

The complication in treating chronic PTSD, where the identified trauma occurred many years ago, is that the PTSD almost always becomes enmeshed with other serious problems in living, such as substance abuse (a dual disorder in 66% of our patients), severe family and other interrelationship problems, and employment. Finally, other psychiatric disorders per se also may be present, that developed prior to the war, or developed simultaneously or subsequently to PTSD. These associated disorders (i.e., depression, anxiety, substance abuse, impulse control) may require a treatment regimen per se, such as psychiatric medications, in addition to PTSD-specific treatment.

INPATIENT PTSD TREATMENT; STRATEGY AND RATIONALE:

From clinical observation, it is clear that there are a number of veterans with moderate and severe, chronic PTSD and associated problems for whom -outpatient treatment and/or acute (general psychiatry) inpatient treatment have proven insufficient to satisfactorily resolve the PTSD and associated symptomology. Secondly, there is a sub-group of veterans living in relatively isolated geographic areas for whom regular outpatient treatment is unrealistic or impossible due to lack of available resources and/or the attitude of the veteran and the severity of his/her problems. It is our conclusion (and of most experts in the field) that the assessment and treatment of severe, chronic PTSD and associated symptomology that has become ingrained over the years is particularly difficult, and requires a multi-faceted approach, typically incorporating bio-psycho-social, inpatient and outpatient treatment.

A unit such as ours provides the intensity, comprehensiveness, and duration of treatment, in a protected environment, that literally only can be provided by a designated PTSD unit. Concentrated attention must be paid to (1) relevant pre-military, military and post-military factors, (2) co-existing psychiatric disorders along with PTSD, (3) the actual war-and-homecoming trauma, and (4) critical "here and now" survival issues regarding family, other relationships, work/school/income. Other major benefits of participating in and completing a PTSD unit program can include restored and enhanced self-esteem, re-connecting to other people in a very meaningful way, renewed optimism, and increased willingess and ability to assume responsible and satisfying lives.

THE AMERICAN LAKE VAMC PTST PROGRAM:

Our program began with a pilot group of six patients in March, 1985. We have pre-bed, "short-stay" and rehabilitation inpatient, and after-care components.

Pre bed services include orientation, information and limited counseling to veterans and their families who are interested in or actually applying to the program, or who have been accepted and placed on a waiting list.

Short-Stay (7 beds): Once a completed application packet has been received from both the veteran and referror, and reviewed, most applicants are scheduled for a 72 hour admission for orientation to the program, detailed assessment and disposition regarding possible completion of additional treatment (such as substance abuse or peer group experience) prior to admission to the rehabilitation component. Program graduates who require a short-stay readmission to stabilize or prevent an acute inpatient hospitalization also utilize the short-stay beds.

Rehabilitation Stay (24 beds): This is the targeted 11-week, intensive inpatient treatment component. A "class" or group of 11 - 13 veterans is admitted and proceeds through the 11-weeks together (after 5 - 6 weeks a second group is admitted; thus there are two groups at any one time in this component). In the 11-weeks, the veterans go through a number of psycho-educational classes (anger control, stress management, sleep disorder, etc.) and several different "thematic" therapy groups, such as war-focus, post-war and here-and-now group therapy. The latter stage of the stay includes community-reentry, vocational rehabilitation, and relationship classes. Biologic treatment (e.g., psychiatric medication) is utilized as appropriate.

After-care: We strongly encourage all graduates to engage in continued after-care with a resource (us, Vet Center, fee/contractor, MHC, etc.) for at least six months and up to two or three years. The time required varies, but is essential to solidify inpatient gains and continue treatment on issues not yet completely resolved.

Comments About Several Elements Of Our Program Design

1. Emphasis on Treatment of Chronic, Multi-Problematic Conditions. We made the decision to maximize the provision of intensive, longer-term inpatient treatment for any eligible war veteran with chronic and severe, entrenched problems of PTSD and associated symptoms such as depression, anxiety and substance abuse. The primary reason for this decision: this needed level of treatment literally was and is unavailable elsewhere in either the VA or non-VA sectors. Indeed, the next two closest designated VA PTSD units are in Topeka, Kansas and Menlo Park, California, and to our knowledge no longer-term inpatient PTSD units exist in the private sector.

To briefly illustrate some factors about the patients we typically treat: (1) about 60% have a post-war history of multiple acute psychiatric hospitalizations and various outpatient treatment episodes for PTSD and associated symptoms, and a sporadic or poor work-history. About 30% have had some prior acute hospitalizations and/or outpatient treatment. Approximately 10% have a relatively normal-appearing post-war history until the last few years when there has been a progressive or significant deterioration in functioning. (2) Sixty-six percent (66%) of our patients have a substance abuse history and most of this sub-group have had several admissions to substance abuse treatment programs, and (3) about 80% of our patients prior to admission and about 65% upon admission to our program have been on one or more psychiatric medications.

2. Waiting List And Chronic vs. Acute-Oriented Treatment: Our program quickly developed a substantial waiting list of interested applicants - this list held at about 100 veterans for almost two years, and recently has grown to about 143 veterans. Because of the extensive waiting list, the availability of acute inpatient treatment elsewhere, and the fact that our staffing was and is not sufficient to provide both acute psychiatric inpatient treatment (e.g. acutely suicidal or homocidal) and PTSD rehabilitation treatment for chronic, severe,

multi-problematic veterans, we chose to emphasize the provision of the rehabilitation treatment aspect of chronic conditions (veterans in need of acute hospitalization will utilize acute inpatient treatment and attain some degree of stablization prior to admission to our program).

We could not justify a waiting list and cohort admission policy if we were designed to provide acute hospitalization treatment. And we could not possibly provide the quality of treatment to impact on chronic conditions that we do, while at the same time operating as a crisis or acute-oriented program. There are acute inpatient treatment facilities available, elsewhere, but we are the only inpatient rehabilitation-oriented treatment for chronic PTSD and associated conditions in about a ten state area. An so this is our philosophy of the optimal way to utilize our resources, minimally duplicate other services available, and be able to make a significant impact on chronic, severely malfunctionining veterans, many of whom do not live within commuting distance of our program.

3. Requirement for applicants to be in current outpatient treatment. We were the first (and may be the only) designated PTSD unit to generally require that veteran applicants currently be in outpatient counseling with someone (VA or non VA), and that the referror complete a referral assessment, along with the veteran's application. These requirements help the referror, veteran applicant and the PTST program to best determine motivation for treatment and if a reasonable effort at outpatient treatment has been attempted and found to be insufficient.

4. Cohort (Group) Admissions: Veterans are admitted together (cohort group admissions) in groups of 11 - 13 veterans. Each group is "closed", in that no new members are added after the third week of the inpatient program, and the group goes through all of its classes and sessions as an intact peer group. We are one of three VA-designated PTSD units to utilize a cohort admission policy; however, about 13 out of the 14 units do ascribe to the critical importance of the peer group as primary to the stress recovery process.

A cohort admission policy is based on the premise that completing the 11 weeks as an intact peer group offers significant advantages; it (1) promotes group bonding, cohesion and trust at an accelerated pace, (2) reduces the repetitive and time-consuming routine required to introduce and integrate new members, (3) allows the veteran to have a positive and intact experience with a peer group of veterans (in contrast to the war experience) and (4) significantly increases the probability that group members will form a strong, supportive social network that continues following graduation - which is extremely important to continuing their stress recovery.

On the other hand, perhaps the two negatives to a "cohort" admission policy are (a) some vacant beds will go unfilled if someone prematurely leaves the program prior to completion of the targeted length of stay, and (b) there is a tremendous amount of work needed to continually coordinate admissions of groups of vets from several states. The hospital has been willing to let us keep such beds vacant (to protect the cohesion and bonding of the group) if and when vacancies occur. This is possible in part because we and our referrors also do pre-bed screenings (by assessing adequate motivation and preparatory PTSD-treatment work) that has resulted in a 91% completion rate for vets who enter the 11-week component.

We have been able to establish meaningful, collaborative working relationships with a host of potential referrors and colleagues in both the VA and non-VA community who can provide outpatient treatment and/or acute inpatient treatment prior to and possibly following entry into our 11 - week component (47% of the veterans are referred by VA Medical Centers, 24% by Vet Centers, and 22% by Fee-contractors.

5. The establishment of a viable therapeutic community (T.C.) is essential to inpatient units. There is a dramatically enhanced positive impact on the stress recovery process of having both the staff and veteran community working together, and the vet community also working with each other "outside" of the scheduled activities. This is part of the responsibility - building process that is essential to stress recovery, and the vets must see that they have actual responsibility and decision-making powers - not just lip service from the staff. We structure legitimate responsibilities for patients regarding such areas as recommending consequences for rules infractions, and modifications to the rules and regulations of the program. Such patient in-put is positively impactful on the veterans and contibutes greatly to minimizing the "we-they" split that Vietnam vets frequently engage in; such splitting is the achilles heal that has seriously damaged numerous programs working with Vietnam veterans.

6. Areas With No Availability of PTSD Resources: Because of the population demographics and uneven distribution of PTSD-knowledgeable resources in the greater Northwest, we discovered that there is a significant pool of veterans in remote, less densely populated areas, who do not have needed resources close enough to allow them to engage in acute inpatient or regular outpatient treatment, or in aftercare following acute hospitalization. Thus, we have had to provide "earlier level" stress recovery interventions with this sub-group of veterans, as appropriate resources simply do not exist in many geographic areas.

7. The Need For After-Care: Finally, we discovered after the first year of operation, that our assumption that we could devote little effort to outpatient (aftercare) treatment, was incorrect. We have developed substantial outpatient services because it quickly became clear that some of the inpatient gains made might be temporary if the veterans did not rather quickly become engaged in after care treatment with someone. Aftercare was needed to consolidate the gains made, deal with issues for which there was not sufficient time to attend to in our program, to deal with additional issues that arose following discharge, and/or to effectively deal with familial, employment, substance abuse and other chronic post-war problems in living. A number of our graduates preferred to obtain their aftercare from our staff, who had by now become intimately familiar with these veterans; and some aftercare resources were only capable of providing early-level PTSD interventions but were not expert in the latter stages of stress recovery. To receive aftercare, a number of veterans have had to face the issue of whether they were willing to relocate from a very isolated geographic area where needed aftercare simply was not available.

PRELIMINARY REPORT OF FOLLOW-UP RESEARCH WITH PROGRAM GRADUATES.

The results of the combined efforts of numerous VA referrors (VAMCs and Vet Centers) and non-VA referrors (such as fee-contractors and community mental health centers), along with our intensive inpatient efforts and selective aftercare (outpatient) efforts, have been highly satisfactory for a significant majority of the veterans we have been able to treat. While a detailed analysis and report of a substantial follow-up study on graduates of our program is in the middle stages of preparation, let me share a few preliminary results with you today.

Results of a substantial follow-up questionnaire (developed by Shawn Kenderdine, Ph.D. and myself) and two standardized tests mailed to 180 graduates of the program revealed a preponderance of positive feedback, and some significant areas of concern. Forty-seven percent (N=85) of the questionnaires were returned completed - a very high percentage considering the length of the questionnaire and the mobility and chronicity of the veterans' problems. Pre- (obtained prior to admission), and post-measures (obtained an average of 13 months post-hospital discharge) revealed the following: (1) a strong trend in decrease in intrusive symptoms (recurrent dreams and thoughts, distress at exposure to events symbolizing the war-trauma, etc.) approaching statistical significance at the .05 level (.054) (Impact of Events Scale); (2) a strong trend in decrease in an overall set of PTSD symptoms approaching the .05 significance level (.052) (Mississippi Scale For Combat-Related PTSD); and (3) a dramatic, statistically significant decrease (.009) in an overall set of PTSD and associated symptoms (our own PTSTP-constructed symptom list).

In another set of findings, the veterans identified the salient problem areas that they believed had been improved, and not improved. In response to the following two questions, the most frequently identified answers were as follows: (1) "In what ways do you feel the program helped you to change in a positive way?" Out of 191 positive responses, 36% identified aspects of self-esteem, self acceptance and awareness; 27% identified relationships and other numbing/avoidance areas; and 10% "locus of control" areas, e.g., - realizing that they have the responsibility and ability to change. Fully 27% of the respondents also did not identify any problem areas that they felt "the program had not helped them with". (2) "In what ways did the program not help to improve problem areas?" Out of 104 negative responses, 11% identified no change in "other" psychiatric symptoms, i.e., - depression and anxiety; 10% identified continuing relationship problems and other numbing/avoidance; and 8% identified intrusive symptoms. Finally, two veterans stated that the program provided no positive results.

I want to emphasize these are the preliminary results of early data analyses; more refined data analyses is underway. Overall, we consider these results to be quite positive. We do continue to be concerned about the endemic problems in relationships of a number of veterans, and the apparent inadequacy of the length of the program for a significant minority of the veterans to better resolve serious issues. Well-designed outcome studies of any kind of PTSD treatment are almost non-existant; hopefully, results of such research as reported above, and other efforts underway by our program and other PTSD treatment providers, will allow for a reasoned analysis and data base for future decisions regarding resource allocation and treatment efforts.

LESS THAN POSITIVE FACTORS THAT MAY IMPEDE THE IMPLEMENTATION OR ON-GOING FUNCTIONING OF A PTSD UNIT.

I cannot overemphasize the wide-ranging and negative impact on inpatient PTSD units of the overall VA budget situation and the manner in which the VA has determined allocation of available resources. Apparent VA budgeting shortages, competing priorities nationally and locally, and a funding reimbursement policy that penalizes any longer-term psychiatry inpatient programs, are at the heart of the problem. This is particularly damaging locally, in that most local VAMC officials who are involved in resource distribution decisions for their VAMC continually must decide about where to allocate scarce resources. Since the inpatient PTSD program obviously is run "at a loss," (e.g., the break-even point for PTSD or point beyond which the local VAMC "loses" money on a given inpatient is about three weeks - and our targeted LOS is 11 weeks (which we consider to be absolutely minimal to address the severity and complexity of the problems of our patients). The impact of this on local officials is for some to take the attitude, "why put additional resources (or maintain the same level of) in a money losing program?" This, in turn, has major significance anytime our program has a vacancy, for example; justification to replace the vacancy and action to authorize the request typically may not be forthcoming in a timely manner, if at all. Even broader in scope, there is a general perception throughout the VAMC by a number of other programs and staff that they are in effect working so very hard at least in part to support "money losing programs" such as ours! The resulting resentments and attitudes by some of course impact negatively on the morale of both the PTSD staff and patients, and on the maintenance of optimal working relationships.

There were/are a number of specific factors present in the VA system that make it difficult to have viable inpatient PTSD units. I want to identify, in my opinion, what these were/are:

1) Too many vets and not enough resources. There are 143 veterans on our waiting list: 77 veterans have submitted written applications and are waiting an average of four months to receive a three-day screening and orientation admission; 66 veterans have completed their 3-day admission and are waiting an average of 5-6 months to enter the 11 week component. We simply do not have the resources available to meet the past (three years of operation), current or foreseeable future clinical needs of war-veterans with PTSD and associated problems for whom acute inpatient hospitalization and outpatient treatment are insufficient.

2) The VA budget squeeze and Resource Allocation Methodology (RAM): Some of the negative impacts are in the following areas:

a. Length of stay The original targeted length of stay (LOS) for our program was 14 weeks, e.g., three months. This LOS had been arrived at through our realization that the evolving VA reimbursement policies to local VAMCs would preclude any longer LOS, and we tried to pick a LOS that our combined clinical knowledge suggested might be minimally possible to significantly impact on severe, chronic PTSD and associated problems. However, due to subsequent budgetary pressures on ALVAMC and the inherent cost-loss of longer term inpatient psychiatry programs of any kind, the hospital administration put considerable pressure on us to lower our targeted LOS; within 14 months we had to drop the LOS to 13 weeks, and then to 11 weeks. At this point I was very insistent that this was the absolute minimal period of time (with the vets we treat) to effect significant therapeutic changes and not get into a "revolving door" process of "prematUre" discharge and readmission, etc.

b. Loss of staff positions. The local budget crunch also resulted in three of our nursing staff slots being reassigned in July 1986, to "more cost-productive" programs elsewhere on the station. In addition, two additional positions had been held vacant for substantial periods of time (16 months and

12 months respectively); this resulted in a net reduction from 28 to 23 staff (an 18% reduction in assigned personnel) for most of the past year. During this same period we also had a 29% increase in outpatient visits, from 1700 to over 2400 visits yearly.

c. Restrictions On Readmissions. Another result of the budget squeeze is the local decision by some hospitals to severely restrict readmission to the units; this is quite ironic, in that the significantly reduced targeted LOS for the programs greatly increases the likelihood that the LOS will be insufficient for many of the veterans admitted in the first place. About 10% of our beds are occupied by former graduates who need the additional time to continue intensive inpatient treatment. The clinical results for such readmissions have been strikingly positive for the most part.

d. Overnight Passes. "Overnight pass days" (when the patient is gone from the hospital past midnight) do not count as a reimburseable census bed day of care (in other words, such beds are considered "vacant" for bed census count, and for reimbursement purposes). Thus, longer-term programs such as ours are significantly penalized if we allow veterans to have weekend overnight passes sufficient to facilitate their transition back to the community. This is particularly impactful in a longer-term program vs. in an acute hospital stay. In addition, the official "average daily census" count is artificially low in direct proportion to the number of overnight passes taken.

e. Discharge Summary Restrictions. Because of the budget crunch, all programs at ALVAMC have been required to restrict their discharge summaries (which describe the course of hospitalization) to about two pages whether the patient has a four day or four-month period of hospitalization. This is particularly impactful on a program such as ours, due to the tremendous number of problem areas that the patients are assessed and treated for over 11 weeks, plus the fact that so many of our veteran patients reside in distant locations. Therefore, the discharge summary is the major and most efficient means of communicating to post discharge referral sources (who will be following the patient after leaving our program) in order to facilitate continuity of care. However, a two page discharge summary for an 11-week stay is sorely lacking and our staff have to spend considerably more time on the telephone conferring with referrors, instead of providing services.

f. Program Cost Analysis And Cost-Per-Day Of Bed Care. The PTSD units are not a separate item in the ADP system for the Veterans Administration. Thus, costs and income-generating productivity for our inpatient services are averaged in with all other acute and longer-term psychiatry programs in the hospital on all centralized official statistics and reports. There also is not a national PTSD unit stop code for outpatient visits; all OPT visits to our program are collapsed under "Mental Hygiene Clinic" statistics. The result of the above two practices is that we continue to be seen as substantial money losers, and yet, there is no official VA cost/income breakdown by various psychiatry programs (with the exception of alcohol and drug substance abuse programs). The recent calculations of our psychiatry service have confirmed my long-standing belief that our PTST Program costs are significantly less (about 16% than most other psychiatry programs), and yet, we continue to have our cost averaged in with the costs per bed day of the more heavily staffed acute and severe chronic mental patient programs on all official cost distribution reports. Finally, the complexities of assigning "credit" for outpatient visits to various programs apparently are such that the VA has yet to apportion such to various services or to individual programs. This is particularly negative to an inpatient program such as ours that generates substantial outpatient visits, which have yet to be "officially" credited to the PTST Program. The result: there is no way to accurately discern actual costs and productivity for PTSD units on any official VA reports.

g. Collateral Visits. Most mental health professionals would agree that for a number of psychiatric conditions, the family system is often times critical to successful treatment of relapse by the identified patient, in this case the veteran. This would obviously be critical concerning PTSD of a chronic and severe nature, where the family system over the years has become enmeshed with the chronic malfunctioning of the veteran. And yet, the latest VA reimbursement policy for collateral visits is to provide a flat, $100 per capita reimbursement per unique collateral social security number. In other words, whether a program sees any family member one or 100 times, the reimbursement is $100. Let me give one example of how this impacts on our program: we started a children's group (ages 11 - 19) several months ago (a seriously neglected population) in an attempt to help children of vets with severe PTSD symptoms better understand and interact with their fathers, and how to take better care of themselves. This is the first time that many of these children have had such an opportunity, and the years have resulted in an accumulation of misperceptions, resentments, etc. All staff and children involved in this group are very excited about the therapeutic benefits; yet, the fiscal policy regarding collateral reimbursement is that we literally must provide this group at no direct-cost benefit to our program (and indeed at a cost loss, in that staff time could be spent on other more financially lucrative interventions, such as veteran outpatient visits). Both clinical needs are important, of course, but the fiscal policy seriously restricts our clinical judgement of how to best deploy our limited resources for maximum therapeutic gain. The same impact applies to our spouse support group and to our couples' group. In my opinion, the flat $100 reimbursement practically insures that PTSD related family issues must essentially be ignored by VA practitioners.

h. Transitional (Hospital To Community) Re-entry Supports. Most of the vets we treat have a substantial history of marginal, poor, or crisis-filled functioning since the war. To deal directly with their war-related issues addresses only one part of the problem as manifested 20 years later; functioning in the real world, to include meaningful daily structured activities (work, school, volunteer, etc.) is a large hurdle to many of these veterans. Indeed, it is completely unrealistic for many such veterans to go from an acute or longer-term hospitalization straight to a full-time job or full-time schooling. What is missing or lacking are programmatic and financial supports, such as a sheltered, transitional living situation; and aggressive part- and full-time job development, placement and work retention supports. For example, we do provide a "work/school coping outpatient group" in the evening for "higher-functioning vets" to deal with here and now issues and progress. This is a very important group; however, many of the vets are not able to transition from non productive to productive lives in terms of a graduated series of increasing levels of work-related responsibilities, from "Incentive Therapy" or compensated work therapy assignments while an inpatient (for which funds are sorely lacking), to part-time to more full-time work and schooling.

i. Urine Testing To Monitor Illicit Substance Usage. Our patients have a 66% co-morbidity of substance abuse (a classic numbing and denial mechanism). Probably all PTSD treatment experts would agree that the stopping of substance abuse is essential to effective PTSD treatment. However, budgetary limitations have required our program to routinely test only about seven (out of about 24) inpatients once weekly through urine specimens to detect possible substance useage. We do not believe this is an adequate level of mönitoring. Ironically, at a time when random testing of VA employees for possible illicit substrance useage is about to begin, budgetary restrictions prevent us from testing a clinical population that has a documented substance abuse history.

j. Travel Expense Reimbursement For Veterans. Our program (and most of the other designated units) is a multi-district, multi-state and multi-regional resource (the next two closest such program being in Menlo Park, CA, and Topeka, KS). Thus, the issue of travel expense reimbursement for veterans entering our program is very important. VA Medical Centers will pay for service-connected veterans (with a $22 deductible round-trip) for distances only beyond 100 miles. Non-service connected vets pay though their own resources or through other assistance - such as from a service organization. In effect, travel fund limits are an extreme problem for veterans who have a lower-percentage service-connection and/or who are low-income and reside outside this medical district. This describes the majority of our patients, as the primary locations of referral to us, are, in rank order by state: Washington, Oregon, Idaho, Montana and Colorado, and Hawaii, Nevada and Utah. And most of the referred veterans have had their income-producing abilities seriously impaired, at least in part, by war related problems.

3. Personnel classification of peer counseling positions. We have had difficulty in getting high enough grade levels classified through Personnel Service to be able to attract highly qualified persons (with substantial backgrounds in PTSD treatment who did not happen to have a MSW, PhD or RN degree). In contrast, the grading structure in the Vet Center Program is significantly more liberal in terms of giving credit, grade-wise, for relevant experience and various level of educational attainment other than MSW, PhD or RN For example, we have not been authorized to go above a GS-9 for master's degree plus substantial PTSD treatment experience. This has restricted our initial recruitment efforts, and ability to fill vacancies.

In concluding this section on impediments to successful inpatient PTSD unit functioning, and the pervasive impact of the RAM, I want to emphasize that the rest of the hospital also has been feeling the budget crunch; and we seem to get "our fair share of a restricted budget." However, the impact of the VA reimbursement model as it now stands is to severely pressure the local hospital to redeploy staff to "high revenue producing programs" and away from longer-term inpatient programs. The hospital literally has been forced to be very conservative in terms of filling our staffing needs, and in delaying or not back filling vacancies. Still, relatively, we are better off staffing-wise than a number of other designated units. My question is: if the Veterans Administration does not have a priority mandate and sanction to support longer-term programs for war-veterans with severe, chronic, war-related PTSD and associated problems, then who will or should offer such programs?

POSITIVE ASPECTS THAT WERE PRESENT AND NECESSARY TO THE SUCCESSFUL ESTABLISHMENT AND ON-GOING FUNCTIONING OF THE AMERICAN LAKE PTST PROGRAM:

Now I would like to provide a fairly comprehensive itemized listing, with brief commentary, about numerous factors that were helpful to the establishment, implementation and on-going functioning of our program.

1. I received very positive and genuine initial personal and professional support from several key figures at ALVAMC during and following my recruitment: the Chiefs of Psychiatry, Social Work, Psychology and Chief of Staff. In addition, the Chief of Nursing, and Associate Director and Hospital Director were all suportive; most of the rest of the hospital at least took a "wait and see" attitude, with some significant resentments about our"special program" status.

2. While I am a professional psychiatric social worker by training and degrees (MSW, DSW), as the PTST Program Director I was placed under the Chief of Psychiatry. Because the former (Cheong Chai Cheah, M.D.) and current (Steven C. Risse, M.D.) Chiefs of Psychiatry have been genuinely supportive of the PTST Program, organizational placement under psychiatry has provided me with a very strong base (to be placed under any clinical service chief not genuinely supportive would be disastrous). Also, because I was from a social work background and under psychiatry, I have had a built-in support-base with both psychiatry and social work services.

3. I have received genuine sanction from the various service chiefs, Chief of Staff and Hospital Director, to be the "Director" of the program, and not just a "coordinator" of the various disciplines. Too often, program chiefs or directors in the VA system actually are "coordinators" only, and the functions, expectations, etc., expected of staff from various disciplines are only very loosely responsive to the program chief. Instead, staff are much more directly responsive to their service supervisor (psychiatry, nursing, psychology, social work, etc.). There is good rationale for this VA system of "dual line of authority", However, an innovative program such as a PTST program must have a director, not a coordinator, because of the frequent number of changes and adjustments required in the program, and the "expanded" and non-traditional functions required of most of the staff. (I have heard that conflicts with dual lines of authority have been quite problematic at several other specialized units). Also, a total of eight of the 28 original positions were under psychiatry service and hence under my direct professional and programmatic supervision.

4. The various service chiefs allowed me to creatively utilize personnel from their services (e.g., psychiatry, nursing, social work and chaplain services) in a manner that was not restricted to the "traditional" duties of the position characteristic of a general psychiatry or mental health setting. For example, I was allowed to utilize Licensed Practical Nurses and Nursing Assistants as class and group facilitators and as case managers (roles often not typically allowed). To be able to utilize the staff's talents and interests to address the needs at hand, in essence regardless of discipline, is essential to a successful program.

5. The original staffing pattern that was assigned to the PTST Program was based largely upon a "traditional" staffing for a 30-bed psychiatry ward -- to include a substantial number of nursing personnel (about half of the staff). I knew that our program did not require that half of the original staff of 28 be "traditional" nursing personnel; we required some personnel who could provide PTSD knowledgeable services from a peer counseling perspective. This judgement was based upon my prior treatment experiences with Vietnam veterans and my conviction that an integration of both "professional" health care, and peer or street-oriented-and-wise staff, (who also could function as attainable role models for the patients) was essential to optimal service provision. Thus, I requested and received permission from the Chief of Nursing and Chief of Psychiatry to convert five LPN positions to MHA (Mental Health Associate) positions. The Position Descriptions (P.D.s) were based, in part, on Vet Center counselor P.D.s. The presence of a substantial number of war vet staff has allowed for much quicker establishment of trust with the vets, as well as providing a mutual experience base for providing expert peer-oriented counseling. (In this regard, our program is unique among the 14 programs. About 60% of our staff are war-vets; to my knowledge, almost all of the other programs have less that 20% war vet staff and perhaps one other program director is a war-veteran). The presence of significant numbers of qualified war vet staff, including leadership positions, has been one major factor in our ability to facilitate the recovery process and prevent serious incidents from occuring on the ward of which we have an exemplary record.

6. Three other major factors contribute to our successful results:
(1) our strong therapeutic milieu and "self-help" expectations, whereby the 24 vets themselves provide a significant amount of the support required for such a program; (2) our nursing staff on the evening and night shifts, whose personalities and skills are very conducive to helping to cool down and resolve, rather than be rigid and authoritarian; and (3) my requirement that most of the non-nursing staff work at least one "late" shift, e.g., afternoon-evening, weekly. This in effect means that about 10 additional staff provide some evening services (a) on the ward when typically there only would be nursing personnel present or (b) off-station. We thus both increase the continuity between day and evening care, and increase our evening counseling capability during unstructured hours when most of the vets are awake and perhaps still processing issues from that day.

7. Nothing is more important than an adequate number of staff and their attitudes, belief and skills regarding PTSD and the veterans we treat. Do our staff care, are they knowledgeable, and do they have the requisite skills to work with chronic and severe PTSD? While most of our staff did not start in our program with a PTSD treatment expertise, many did have other areas of expertise, such as anger control, stress management, substance abuse treatment. And several of the peer Vietnam veteran staff I hired also had substantial prior experience in PTSD specific treatment (another reason for hiring them). Our staff really care and are positively impactful -- and that is confirmed loudly and clearly by the vets we treat.

8. The original staff assigned to our program: When the program was established in 1985, essentially the entire nursing staff from a severe, chronic psychiatric patient ward (that had just been closed down) was assigned to be the 14 nursing staff of the PTST Program; three additional staff were screened out by nursing service and assigned elsewhere. In addition, other nursing personnel had been given the opportunity to apply for positions in the

PTSD Program. Due in large part to the screening skills of our very knowledgeable nurse manager (Anne Gregory, R.N., a Vietnam veteran), the quality of nursing personnel screened and assigned was an asset. However, it is my understanding that other specialized programs for Vietnam veterans (including several established in the 1970s and subsequently closed down) were opened with staff who were assigned (at times arbitrarily) to the program and without the proper attitudes and skills; the results were quite negative, usually manifested by numerous "acting out" incidents, substantial substance abuse, etc.

9. The number of staff originally assigned to the program was sufficient (28) to run the 31-bed program and accompanying outpatient treatment. This is labor-intensive work, especially the critical early and middle stages of treatment in an intensive inpatient setting. I have heard about the small number of staff allocated to some of the inpatient units; such units are doomed, in my opinion, to having a continuing series of crises and upheaval. Our staff ratio (for intensive inpatient services only) at this point is about .65 staff to each inpatient; in my opinion, this ratio is the minimal necessary to allow for quality intensive inpatient PTSD treatment.

10. I was given the authority to assign irregular tours of duty, in order to maximize off-shift coverage and our off-station activities and to facilitate several of our para professional staff advancing their formal education. These are critical needs; rigidly restricted "normal" tours and location of duty would have made it impossible to meet the needs of the vets we see, or to facilitate peer counseling staff to upgrade their clinical skills.

11. Several years ago, the Washington State Department of Veterans Affairs established a fee contractor program similar to the Vet Center fee-contractor program; it was established to finance fee-contractors in the many areas of the state where the Vet Center program (apparently due to limited funds) was not able to establish fee-contracts with. This is a critical resource, especially necessary in areas such as the greater Northwest where there are few centers of high density population. Consequently, many of our vets are literally not within any kind of reasonable commute to the closest VAMC, Vet Center or Vet Center-fee contractor; of[illegible]es, they are in areas where there also are no other private or public counseling resources knowledgeable about PTSD among war veterans.

12. We soon instituted "staff support" groups, on a voluntary basis (meeting for all interested staff, one time weekly on Friday afternoons) to talk about ourselves, how the week went, if any of our own "personal" issues were triggered through the week's work, etc. Intensive work with PTSD and Vietnam veterans is particularly impactful on the care providers. Program leadership and staff must have the attitude that "counter-transference" dynamics are routine and expectable, and its okay and necessary to talk and deal with them in a safe setting. I would always attend the sessions, as "just another member"; however, my presence and attitude were critical, in that if the staff believed that there might be negative recriminations about anything that was said in the staff support meetings, what needed to be discussed would not have been.... I am also concerned about the potential and actual "burn out" in Vet Centers, and with fee contractors and in other PTSD units.

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13. I have been given the freedom to off-station four of our staff at key locations to facilitate optimal outreach with potential candidates for admission and after-care outpatient contacts with graduates of the program. Each of these four staff spends a block of several hours, once weekly, at community locations in Seattle, Tacoma and Olympia, co-located with two Vet Centers and two community providers, respectively. No, we can't "afford" to have staff off station because of our heavy workload; and, yes, we can't afford not to have several staff off station to facilitate positive collaborative relationships and community presence with numerous referrors, and to extend our ability to provide critical aftercare to veterans from a wider geographical area. Also, we help interested vets to "check out" personally our staff in the more "neutral" turf of the community. This also allows us not to become isolated, and keeps us actively in touch with the veteran grapevine and happenings/rumors in the community (which can make or break any VA program's reputation with veterans.)

14. Our hospital has been willing to allow us to be innovative in other ways: Three examples are: (a) providing needed administrative support to our development of an "Outward Bound" Project (structured overnight wilderness experiences), to determine if such experiences could be helpful to the stress recovery process. It certainly appears to be so, as demonstrated for several years now by Bob Rheault (COL, Ret) with the Northampton PTSD Unit and the Hurricane Island Outward Bound School. Thus, through a grant through Paralyzed Veterans of America, we are now researching an Outward Bound component to our program; (b) administrative leave for two of our staff to respond to a request from a Canadian Vietnam Veterans Association to attend a function in Canada, and to allow our staff the opportunity to provide materials and discussions with this group regarding improving their own "self help" efforts, and referals to us, and (c) administrative leave to network with the state fee contractor program, Vet Centers, etc.

15. We also are "open" to guests, visitors, and the public, and supported in this by ALVAMC. For example, when issues have arisen that have involved the media (such as the recent, very publicized suicide death of a Vietnam veteran, and I was called for a reaction/comment), I have been given permission to deal directly with the media. I have been able to "talk straight" (while protecting patient confidentiality) and to the point, which is part of the reason we have had such a great relationship with the media. The media knows that I and our staff know what we are talking about. Indeed, we have an "open door" policy. We allow media, visitors, potential referrors, potential vet applicants, etc., to visit the program and sit in on various activities (if the vets give their permission). We have no "secrets" about what we do; indeed, a routine procedure is for any visitor to have some time alone with several of the inpatients (who volunteer for this) to hear what "really" goes on in our program, without staff present to perhaps censor or be intimidating. As an example, we have had eight very positive newpaper articles written about us, and we were identified in a June 5, 1980, CBS "60 Minutes" faith in and expect that the vets will be fair and give positives, constructive criticisms, etc. The results have been very positive concerning our relationships with referrors, the media, the public, etc. We have had eight very positive newspaper articles written about us, and we were identified in a June 5, 1988, CBS "60 Minutes" special as an innovative and valuable PTSD treatment program.

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16. American Lake is a beautiful setting and for the past year we have had ample space for therapeutic activities, staff office space, and room for the vets not to feel totally crammed and squeezed. Adequate office space is necessary for the frequent 1-1 sessions necessary to supplement the group treatment. The adequate living space is critical in that many of our veterans are very uncomfortable around groups of people; and for a several-month period of hospitalization, inadequate space is detrimental to stress recovery and the ability by some very isolated vets to complete the program. The fact that we have an entire building for our program is very helpful to our program's identity - an identity very important to the vets we see. Such an identity also is possible if the program had one entire floor, for example. However, fragmented living quarters, especially in shared residence with acute and severe chronic mentally ill patients, has proven detrimental to the establishment of a positive therapeutic milieu and identity at some other programs.

17. We are now developing a good working relationships with ALVAMC Research Service; this is essential to accomplishing the quality of research and program evaluation necessary. The research service must be receptive not only to biological and pharmacological, but also to psycho-social research efforts; our research service is. (On the other hand, clinical demands of the program and the shortage of salary dollars locally make it quite difficult to be able to hire research specialists; consequently, a number of the clinical staff must squeeze in research activities as best they can).

18. Representatives from several service organizations (Vietnam Veterans Leadership Project, Disabled American Veterans, Vietnam Veterans of America, National Order of Purple Heart, Paralyzed Veterans of America, Ex-POWs of America) and the State Department of Veterans Affairs, have made one or several visits to us, and us to most of them, at various functions. We have and want to have excellent relationships with these and the other service organizations; such relationships contribute significantly to positive comments about us with vets and the public, a built-in feedback system about some of our graduates, and a spirit of collaboration and mutual support.

19. As discussed earlier, because of the VA Resource Allocation Methodology, longer-term inpatient psychiatric programs are "money losers" to the local VAMC (unless the programs have a large and rapid turnover in patients; thus, our 91% graduation rate, per se, hurts us in terms of fiscal reimbursement). To the credit of ALVAMC and the Psychiatry Service, the administration has been willing to accept our staff's evaluation that an 11-week intensive inpatient stay is the absolutely minimal amount of time required for the range and severity of problems that we treat, and considering the number of staff and patients that we have. The administration has been willing to continue to in effect absorb the financial losses incurred by our program because of the committment to what we do and the very positive impact we have on relationships with veterans, the media, and the public. On the other hand, we have instituted several program features that significantly minimize financial losses and are clinically needed, such as our extensive pre-bed and aftercare services, and the 3-day "short-stay" and relapse bed component of 6 - 7 beds.

20. The leadership of a PTSD Program must have skills in several areas. To be a PTSD expert is not sufficient to run such a program. Several other skills also are essential: (a) leadership of an administrative and clinical nature; (b) "political" savy regarding the VA system and how it works, including

understanding and dealing with the "dual authority" matrix of service and program; (c) knowing how to walk the fine line between firm limit-setting and flexibility; (d) understanding of cost-efficient services, and the VA reimbursement model; (e) program development skills, in that such programs seem to be in perpetual states of change and evolution; (f) attitude and willingness to relate to Vet Centers, acute psychiatry units, Mental Hygiene Clinics, fee-contractors, and other referrors as colleagues and not as rivals or antagonists; (g) the ability to actually relate with the veterans in the program and have personality and behaviors conducive to and not obstructive or damaging to working together towards the common cause of optimal stress recovery, and (h) finally, and perhaps most importantly, skill in conflict resolution - between and among the patients, patient-and-staff, staff-to-staff, program-to-other-elements in the medical center, and program -to-the-community. The actual process established to resolve conflicts becomes essential both to the recovery of veterans and to the program's stability and survival.

OTHER CONSIDERATIONS THAT IMPINGE ON OPTIMAL PROVISION OF PTSD TREATMENT SERVICES:

1. 21-Day Certificates And Reimbursement For Hospitalized, Service-Connected Veterans: If a veteran is hospitalized for the condition for which he/she is service-connected, there is a formula for the veteran to receive a temporary increase to 100% and corresponding payment at some time following 21-days of hospitalization. However, we have found that this is a very problematic situation, characterized by lengthy delays in our hospitalized veterans receiving the actual money. The problems are many-faceted, including (a)different information being provided to the veterans by various referral sources (both VA and non-VA), (b) the hospital computer data base apparently not containing accurate information about service-connection status for a number of veterans, (c) tardiness in issuance of the 21-day certificate to the Regional Office, and (d) oftentimes lengthy delays in the money being actually delivered to veterans (70-90 days following admission to our program, and the families usually desperately need this money while the veteran is in the hospital). This adds considerable strain on both the hospitalized veteran and the family, and is an additional impediment to some veterans being willing in the first place to make the committment to enter a longer-term program.

2. PTSD Treatment Resources For Veterans In More Remote Geographical Areas: a number of the veterans we see or know about live in rather remote areas, far from any known and knowledgeable PTSD treatment resouces. It appears that one realistic avenue for help open to such vets (short of physically relocating their residences) would by a fee contractor - but Readjustment Counseling Service funds for fee-contractors have been reduced, I understand, over the past few years from over $7 million to less than $5 million. This makes it very unlikely that geographical areas currently un-or under-serviced will have any significant awards of new fee-contractors. Another potential resource is veteran self help groups, co-facilitated by the veterans themselves. However, such groups oftentimes require knowledgeable assistance/consultation to become implemented and remain effective. It would appear to me that such a service (e.g., facilitating veteran self-help groups in more remote areas) ought to be a mandate of the Veterans Administration, if fee-contractors or Vet Centers are not going to service those areas. Programs such as ours, and Vet Centers, are two logical resources to provide such services to potential self-help groups and would appear to be an extremely low cost service, as well. We have received two such requests already, one from a Vietnam Veterans in Canada group, and one

from a group of vets in upper-central Washington. Can such services be sanctioned and provided with sufficient resources (for example, travel and per-diem for an initial two or three day visit to the area to consult and begin the process, followed by periodic consultation visits to the area)? A third alternative is that intensive inpatient PTSD treatment can substitute for (unavailable) outpatient treament, but the issue of needed aftercare remains.

3. World War II, Korean and post-Vietnam-era veterans: About 3% of our inpatients have been war-veterans of World War II, Korea or the Dominican Republic; our experience in having such veterans intergrated with Vietnam veterans has been very positive to both the Vietnam and other-era war-veterans. Our program has been open to all such veterans since our establishment. It is our impression that there is a very significant number of Korean veterans in particular who need a program such as ours, and/or Vet Centers, as well. Specific outreach efforts to these war-veterans and potential referrors are sorely needed in order to make PTSD-related services psychologically accessible to them. (Many such veterans, and both VA and non-VA referrors, continue to perceive programs such as ours as only open and appropriate to Vietnam veterans, in spite of our written eligibility criteria specifying otherwise). We do have three staff who served in Korea (two of them also in Vietnam), and their contribution to the stress recovery of all war-veterans treated here is very important.

4. Women veterans: Our program has yet to have a woman war-veteran with PTSD complete an application for admission (in spite of the fact that we have had two Vietnam women veteran staff, and one civilian nurse who spent 3-1/2 years in Vietnam). My understanding is that most of the other designated programs also have had very small numbers of, or no women war-vets as in-patients. The male-dominated nature of the VA health-care system, the preponderance of male patients, and the apparently negative attitudes towards the VA and government by a number of women veterans with PTSD-related difficulties, all contribute to the apparent lack of significant numbers of individual women war-vets entering PTSD units. I suggest that two or three of the designated PTSD units be identified and provided some additional resources, as "centers" for treating women war-vets (along with male vets), and so advertised throughout the VA and community systems. Appropriately developed with staff expertise, targeted outreach efforts and promoting coordinated small-group (of women war-vet) cohort admissions, in my opinion would promote and optimize the number of women veterans with severe PTSD willing to enter inpatient PTSD treatment. Our unit would be very interested in being one such center.

5. Ethnic minority veterans: We are concerned about the relatively low proportion of ethnic minority vets (particularly Black, native American, Hispanic, Asian, and Pacific-Islanders) who utilize our program -- in spite of some outreach efforts, and affirmative action to attract minority staff.

6. Our assessment of a signficant minority of veterans utilizing clinical services who are very high-risk for suicide or other self-destructive behaviors reveals the following profile; severe and chronic PTSD, substantial and persistent substance abuse history (typically with prior participation in several substance abuse programs), and chronic pain, usually from war-connected physical injuries and/or post-war accidents. The interconnections among these three sets of factors are quite complex and potent. We and the Veterans Administration have much to improve on to better understand and impact on this sub group of veterans.

7. Catchment areas There are no nationally agreed-upon catchment areas for each of the PTSD units. Independently, each unit has defined its own catchment area; some reportedly are very defined and limited (such as restricting referrals to one state). Others, such as ours, have no specific restrictions per se, but naturally receive the vast majority of referrals from the regional area in which we are located (greater Northwest). I am very concerned that restrictive geographic limits set totally independently by some units mean, in effect, that there are veterans in numerous parts of the country who may not be within several states of having a PTSD unit that they could even consider applying to. Until this situation is rectified, our program will continue to not place any firm geographic restrictions on eligibility, or else numerous veterans may not have any PTSD inpatient program available to apply to.

8. Service-connection for PTSD: Whether or not one has a service-connection for PTSD has profound ramifications on availability of treatment: (a) service connected veterans by VA regulation are required to be placed on any waiting lists ahead of all non service-connected veterans; (b) many Mental Hygiene Clinics reportedly have severe restrictions on availability of services for non service connected veterans; and (c) there is the lack of travel reimbursement for non service-connected veterans, which is very problematic with low-income veterans. We all probably also are aware of the very uneven practices nationwide in terms of (a) practitioners giving or not giving PTSD diagnoses, and of (b) VARO rating boards giving or not giving service-connected disability ratings. The upshot of all of this is that a substantial number of veterans with apparent war related psychiatric difficulties are quite handicapped in terms of receiving needed VA treatment because they are not adjudicated as service connected. We also have several national-in-scope studies to date that strongly indicate a significant correlation between exposure to combat, death and dying trauma, and PTSD or PTS symptoms. Finally, it is noteworthy that out of all the psychiatric disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Vol. III-Revised (1987), most mental health experts might agree that PTSD is probably the one disorder in addition to head-injury precipitated disorders whose etiology could be rationally linked to military war-zone service, per se. Because of the preceding factors, I strongly advise that consideration be given to providing a presumptive PTSD service connection, at the 0% level, to all war-zone theater veterans. Any war veteran with possible PTSD-related problems would be able to avail him or herself of needed mental health treatment for PTSD specifically and not be handicapped by the lack of a service-connected rating. This also would provide the message to everyone that war-zone experiences may indeed by hazardous to your mental health, and that it is okay to receive VA treatment (that you are entitled to) for possible war-related psychiatric conditions.

9. Coordination among the various designated PTSD units: There have been two meetings, ever, for representatives of the designated PTSD units (1985 and 1987). The lack of systematic communication, coordination, problem solving and strategizing, etc., among the units is startling. At the very least, I would strongly recommend that a meeting, once yearly, be provided for at least the unit directors or their designees to meet -- perhaps in conjunction with a meeting of the CMD's Special Committee on PTSD and/or with a Vet Center Regional training. If we don't communicate regularly, I don't see how it is possible for us to learn from each other and combine our knowledge for optimal results.

10. Variability among the designated inpatient PTSD units. There is, and appropriately so, a range of treatment approaches and program structure among the 14 designated PTSD units. At this stage in the development of PTSD treatment regimens, there is a significant lack of meaningful outcome studies of any PTSD treatment approaches, let alone comparative treatment outcome studies of alternate methods. The challenge is to promote stability and quality care in the various programs, while at the same time promoting an improved, empirically-based understanding of what works best with what veterans, with what various combinations of PTSD and associated problems, under what conditions, and for what length of time. We have continually received very positive feedback about our program from both veterans and referrors, and our preliminary outcome data offers some support to the efficacy of our approach. Other units undoubtedly feel similarly about their approaches. We must continue to expand the data-based assessment of our efforts, as do all of the other units and other VA treatment components that address PTSD (eg. acute psychiatry, Mental Hygiene Clinics and Vet Centers). The establishment of a common data base and guidance regarding at least a partly common program evaluation protocol for utilization by all of the PTSD units is critical to this endeavor.

11. Innovative sharing/collaboration between PTSD units, Vet Centers, and Fee-contractors: Inherently, the 187 Vet Centers, the several hundred fee-contractors, and the 14 designated PTSD inpatient units have a special relationship with each other. We are inextricably linked due to our uniquely designated mission to treat PTSD and associated problems. Some Vet Center or fee-contractor clients who require inpatient treatment in addition to readjustment counseling are at a serious disadvantage if there is not an accessible designated PTSD inpatient unit. Conversely, if PTSD units, Vet Centers and fee-contractors do not have coordinated pre-bed and after-care relationships, a number of veterans who require inpatient PTSD treatment might not make it to a PTSD unit in the first place, or might not have essential earlier level stress recovery treatment that facilitates optimal progress in an inpatient unit. And, the very needed specialized PTSD after-care for the latter stages of stress recovery following inpatient treatment may only be available, realistically, with a Vet Center or fee-contractor.

In recognition of both unmet liaison needs, and the special relationship that was already developing between the PTST Program and the Tacoma Vet Center (as well as with several other Vet Centers), ALVAMC, the Tacoma Vet Center, and the Region VI Regional Manager approved and implemented an innovative, shared FTEE for a Vet Center/PTST Program liaison person. The FTEE slot was provided by ALVAMC, and the salary dollars by the Regional office (10B/RC6) for a recurring position. This kind of cooperation and built-in systemic linkage between the only two elements in the entire VA system that are designated as PTSD-treatment programs is very needed and useful. All of our programs are so busy dealing with direct service needs that systematic, meaningful linkages with each other seem to suffer.

12. Statement From Current Inpatients, Group 27, PTSD Program.

"Independence Day, 1988

To the Senate Veterans Affairs Committee, Congress of the USA, and all concerned citizens:

We are group 27 of the Post-Traumatic Stress Treatment Program (PTSTP) at the American Lake VAMC, Tacoma, Washington. We feel strongly on three important points:

1) This treatment program is vital to us and to all American Veterans of War. It brings us to some realization of our disorder, and it equips us with some of the tools and skills we need in order to contend with today's society, and to deal with our war-related traumas non-destructively.

2) We know that this program is extremely beneficial to our recovery; this cannot be stressed enough. But it is only a start for us; a foothold on life itself; a new beginning for each of us. We realize also the vital importance of aftercare and crisis facilities (in particular, those here at the American Lake PTSTP) are invaluable aids to our recovery. But they are precisely that -- "limited" and "crisis aids". They are not enough!

3) Vet Centers and fee contractors are without question the most important part of our continuing aftercare (as well as the PTSTP, for vets who live close to American Lake). Therefore, we demand that the Veterans Administration be directed to provide full support for all existing Vet Centers and fee-contractors, and such additional ones as may be needed.

Very respectfully,

The 13 Veterans of Group 27
(From Washington, California and Utah.)"

IN CONCLUSION: While I am the director of the 13th (out of 14) VACO-designated inpatient PTSD units to have been established, I am the fourth in terms of tenure as a PTSD Unit Director; I also know there is a like amount of turnover at other levels of staffing in other PTSD inpatient programs and Vet Centers as well. Working intensively in inpatient and/or outpatient settings primarily or solely with war-veterans with chronic, moderate-to-severe symptomology is very demanding work for all involved. It also is remarkably rewarding to witness and be a part of the positive stress recovery process of so many men and women who went when their country called, and in a number of cases have been paying a painful cost, for many years. Could any mandate regarding provision of mental health services to veterans deserve to be as high a priority for the Veterans Administration than the treatment of war-related PTSD? Not in my opinion.

In closing, I would like to take the liberty to offer a revision of a historic quote by former President John F. Kennedy: is it not time for our country to stop asking what these veterans can do (further) for our country, but ask instead what our country can do for them? (After all, they have earned it.)

TESTIMONY FOR THE SENATE COMMITTEE ON VETERANS AFFAIRS

To Be Presented at the Oversight Hearing
on Post Traumatic Stress Disorder

July 14, 1988

by Robert B. Rheault
Director, Vietnam Veterans Program
Hurricane Island Outward Bound School

TITLE:

OUTWARD BOUND WILDERNESS EXPERIENCE AS ADJUNCTIVE THERAPY FOR VETERANS SUFFERING FROM POST TRAUMATIC STRESS DISORDER

SUMMARY

Outward Bound has been conducting wilderness courses as an adjunct to therapy for veterans who are in-patients in PTSD wards of VA Hospitals. The program has been in existence since 1983 and has proved itself to be an effective aid to the therapeutic process. Both veterans and clinical staff have testified to its value.

Although VA staff have voiced strong approval for the program, it has not been integrated officially into the PTSD treatment model and is presently limited to three hospitals supported by privately raised funds.

POST TRAUMATIC STRESS DISORDER (PTSD)

PTSD is defined technically in the Diagnostic and Statistical Manual of the American Psychiatric Association and will not be repeated here. However, for the purposes of this testimony, I would like to emphasize certain common characteristics of the disorder which are particularly germaine to this therapy:

- Low self-esteem, lack of confidence
- Isolation, inability to get close to others
- Lack of trust
- A tendency to give up rather than stick to a task
- Blaming others for one's condition, not taking responsibility for the course of one's life

TREATMENT OF PTSD

A wide range of treatment modalities are used with veterans suffering from PTSD, including individual therapy, pharmacology and family counseling, but the treatment of choice has proven to be group therapy.

One of the major obstacles in individual therapy - "You don't understand what I've been through" - is neutralized in groups of men who have had essentially the same experiences. Guilt is more easily dealt with as the individual in group therapy encounters others with the same feelings and watches as others gradually master their problems. Rage, psychic numbing, alienation, intrusive-repetitive thoughts, and the inability to live and trust others are corrected as the individual finds meaning in life's experiences through group work. It is as an adjunct to this therapy process that Outward Bound can be most effective.

OUTWARD BOUND

The emergence of Outward Bound can be traced to wartime England in 1941. It arose out of a need to instill spiritual tenacity and the will to survive in young British seamen. What began as a wartime school for survival has evolved into a worldwide organization that offers action-oriented programs for personal growth, service to others, and physical preparedness. Outward Bound takes people away from their daily routine in an effort to teach them to cope with the unfamiliar and uncomfortable, in search of an opportunity to understand, test, and demonstrate their own resources and leave behind self-imposed limits. The founder of Outward Bound, Dr. Kurt Hahn, sought to teach participants to persevere in the face of great difficulty while maintaining the highest standards of human cooperation and mutual service. In Dr. Hahn's words, "The aim of education is to impel people in value-forming experiences (and) to ensure the survival of these qualities:

- an enterprising curiosity
- an undefeatable spirit
- tenacity in pursuit
- readiness for sensible self-denial
- and, above all, compassion"

The major goal of Outward Bound is personal growth. The wilderness and the skills taught to deal with it are the vehicle for that growth. Since its founding, it has become apparent that the Outward Bound concept is applicable to a wide range of groups: young people, youths at risk, educators, corporate executives and managers, women over 30, and alcoholics. It is, therefore, not surprising that in the 1980's Outward Bound is effectively conducting courses with Vietnam veterans who suffer from PTSD.

THE OUTWARD BOUND PROGRAM FOR VETERANS

Since May of 1983, the Hurricane Island Outward Bound School has conducted thirty-four special courses for Vietnam veterans from the PTSD unit at the Northampton VA Medical Center in Massachusetts. The School also assisted in the development of a successful "pilot" program for PTSD patients at the VA Medical Center in Tacoma, Washington during the spring and summer of 1987. These courses were specifically designed by Outward Bound staff in collaboration with VA staff and were based on previous Outward Bound experiences with individuals who had psychiatric problems.

The courses consist of many standard Outward Bound activities--camping, winter survival, hiking, peak ascents, rope courses and rock climbing. They are notable and special in the amount of time and effort devoted to talking, listening, and counseling. Emphasis is placed on taking responsibility for one's own life, sticking with difficult tasks through completion, rediscovering a sense of pride in accomlishment, and enjoying the camaraderie of a shared challenging experience.

These courses were rated very highly by both participants and observers. Extensive debriefings were carried out with participating patients and therapists and the concept has received enthusiastic response and support from psychiatrists, psychologists, therapists and counselors.

Outward Bound has now become an integral part of therapeutic treatment in the PTSD unit at the Northampton VA and the PTSD unit staff at both Tacoma and Augusta are prepared to make this activity a permanent part of their program.

It is important to note that the nature of these courses is such that participants accomplish tasks such as peak ascents, rappels and rock climbs that appear difficult or even impossible. Patients work together as a team and become a close knit unit. They have to trust one another and Outward Bound staff as well, as they engage in activities with a high degree of perceived danger where a buddy must provide the safety.

The course takes place in the middle of the veteran's hospital stay. He returns to the hospital with a renewed sense of self-esteem, a knowledge gained through hard effort that he can do tough things, a feeling of brotherhood with his fellow participants that enhances continued group therapy.

The clinical staff back at the hospital find that veterans returning from Outward Bound have often made important breakthroughs and are ready to work harder for the balance of their hospital stay. (See Appendix A for letters from VA clinical staff.)

A further value of the wilderness component in the midst of a hospital stay is that it breaks the deadly cycle of institutionalization, physical inactivity and lack of responsibility that inevitably occurs in such a setting. In the field the veterans are active, energized, excited, challenged and fully responsible for their food, shelter and well-being. The experience is dramatic and memorable and a positive influence. (See Appendix B for some extracts of letters from veterans.)

FUNDING

The program at the Northampton, MA VA Hospital and the new programs being started at the Tacoma, WA and Augusta, GA Hospitals are all funded by privately owned money.

The Veterans Administration, although it supports and approves the project and actually provided limited funds for some activity at Tacoma in 1987, is not providing any funding.

Outward Bound courses can be conducted for approximately $150 per day per veteran--a cost far lower than in-patient costs.

CONCLUSION

A brief (4 to 5 day) wilderness experience has proven to be a strong catalyst and expeditor in the therapeutic process. It's value in helping to achieve the goals of the PTSD in-patient program is such that it should be integrated as a part of the therapy, not considered an "add-on" and, therefore, not requiring new funding. It costs more than $300 a day to hospitalize a patient in a PTSD unit--probably a great deal more than that. A reduction of three days of hospital time would save $900--more than enough to pay for a wilderness experience.

Action oriented therapy works and is cost effective. It should be part of the VA's PTSD program.

APPENDIX A

MEDICAL CENTER NORTHAMPTON, MA 0106

Veterans
Administration

June 19, 1987

In Reply Refer To: 631/116A

TO WHOM IT MAY CONCERN:

Since May 1983, the Hurricane Island Outward Bound School has conducted over twenty-five special courses for Vietnam Veterans from the Post Traumatic Stress Disorder Unit of this hospital.

These courses were specially designed by Outward Bound staff in collaboration with staff of this hospital and were based on previous Outward Bound experiences in a mental health project which has been ongoing since 1975.

The purpose of these courses was to provide adjunctive therapy to the program in which the veterans were involved at Northampton. We have found that Outward Bound, which provides an intensive and stressful (albeit success-oriented) experience in a wilderness setting, led by Vietnam veterans has proven to be a powerful personal experience leading to enhanced self-esteem and self-confidence. The course quite deliberately recalls wartime experience: backpacks, maps and compasses, physical stress, fatigue, thirst, water that tastes of iodine, sleeping out at night, teamwork, mutual support, fear, unknown territory--in short everything but the shooting. Participants experience again the positive feelings of pride in accomplishment of difficult tasks, camaraderie, the power of joint effort and helping one another. As field conditions trigger memories, there is ample opportunity to talk it through with a supportive group. The Outward Bound staff coordinate with Northampton staff before, during, and after the course to insure that there is continuity in the therapeutic process.

Over the last four years approximately 200 of our patients have experienced the Outward Bound course, which has become an important part of our treatment process. Our evaluation of this continuing project is extremely positive. Both patients and staff of the PTSD unit believe that significant steps forward have been made by most participants in these courses. They have been able to build rapport more rapidly between themselves and staff. They often treat the therapeutic process with more sincerity and openness. Difficult issues have been known to emerge much more rapidly and most importantly a special bond evolves which helps sustain these men not only through the program but also after completion.

Recently, I personally participated in the 26th course of this project and can speak from personal experience of the positive effect it had on our patients and myself. I was able to observe collective problem-solving during difficult physical situations and to participate in the feelings of accomplishment mentioned above. I was impressed with the leadership abilities and training of the Outward Bound personnel, their strict adherence to safety procedures and the range of varying responses which they showed to individuals of differing abilities.

As a result of these experiences we are quite interested in continuing this course which we have found to be an effective tool in the treatment of Post Traumatic Stress Disorder.

Sincerely,

William E. Boutelle M.D.

WILLIAM E. BOUTELLE, M.D.
Chief, Psychiatry Service

MEDICAL CENTER NORTHAMPTON, MA 0106

Veterans
Administration

March 19, 1984

In Reply Refer To: 631/116A

TO WHOM IT MAY CONCERN:

As the Director of the Post Traumatic Stress Disorder unit at the V.A. Medical Center, Northampton, Mass. I would like to express my overwhelming support of Outward Bound as an adjunct to this treatment program. Our association is now about 1 year old including the investigative period and from the beginning, this group of individuals has added significantly to our program.

The course that was developed, although short in time (5 days) has already had great impact on this unit. The men who actually go through the program develop a strong bond very rapidly which continues throughout the entire hospitalization and into outpatient treatment. This bonding helps shorten clinical trust issues between men and staff, enhancing the therapeutic process on the unit.

As each group goes through both programs we are becoming more and more aware of the degree to which the Outward Bound aspect enhances treatment. Actually I am quite proud that we were one of the first programs to work with Outward Bound, combine our skills and work toward helping Vietnam veterans understand their experiences of combat. The days in the field allow our veterans to relive part of Vietnam but in a safe and compelling way. Upon returning to the unit the clinical people can use this experience to help overcome some of the entrenched negativity and fears that often hurt these men.

I personally hope that this program and Outward Bound can have a long relationship together. It is also my hope that other units will eventually be able to introduce this course into their program.

Sincerely yours,

Richard J. Sette
RICHARD J. SETTE, M.S.W.
Director, Post Traumatic Stress Disorder Unit

. MEDICAL CENTER NORTHAMPTON, MA 0106

Veterans Administration

March 24, 1984

In Reply Refer To:

OUTWARD BOUND AS A TREATMENT FOR PTSD

Over the last few years it has been acknowledged by the mental health community that large numbers of Viet Nam combat veterans are suffering from a variety of severe psychological difficulties, which have been subsumed under the label of "Post-Traumatic Stress Disorder"(PTSD). The syndrome has been shown to be related to the intensity and duration of combat experience, among other factors, and consists of a variety of symptoms and behaviors that can be summarized under three general categories.

The first and most difficult category to describe and measure is a generalized reduction of responsiveness to emotions and emotional communication, often summarized as "emotional numbing". The individual will experience a great deal of difficulty with interpersonal relationships, particularly in the context of intimacy, and will subjectively report that he cannot feel any emotions except rage, boredom, and depression. The second category includes a whole range of phenomena such as depression, anxiety, intrusive thoughts and imagery, nightmares, flashbacks, a variety of somatic complaints and psychosomatic illnesses, and so on. Finally, there are a characteristic behaviors and lifestyles including a tendency to remain socially isolated, frequent problems with drugs and alcohol, a tendency toward violence and at times toward criminal activity, and often a history of multiple short-term jobs. A particular individual may demonstrate any combination and permutation of all these phenomena, depending on his personal history prior to, during, and after his combat experience, and in accordance with his innate characteristics.

As a result of the demonstration that PTSD is directly referable to the Viet Nam combat experience, and usually not the result of pre-existing psychopathology, a number of inpatient psychiatric units have been started in Veterans Administration Medical Centers around the country which are devoted exclusively to the study and treatment of this condition. The Post-Traumatic Stress Disorder unit at the

Northampton Veterans Administration Hospital has been in existence since March, 1982, and to date has treated approximately 100 veterans. The unit has 19 beds, and at the present time admits veterans for a five-month highly structured course of treatment. The treatment modalities include medications, individual and group psychotherapy, hypnosis, biofeedback, family therapy, and the indefinable qualities of the milieu resulting from admitting only combat veterans with this particular syndrome. Since the middle of 1983 there has also been an attempt to utilize the Outward Bound program as an integral part of the treatment.

In addition to the well-documented therapeutic effect of Outward Bound in a variety of psychiatric conditions, there is a particular rationale for its use in Viet Nam combat veterans, which relates to the positive aspects of the Viet Nam combat experience. The literature and the general thrust of therapeutic efforts have focussed fairly exclusively on working with the horrors and negative aspects of the war experience itself, and on the hostility of the nation toward and subsequent neglect of the Viet Nam veterans upon their return. There is a general lack of appreciation for the fact that there were aspects of the combat experience that were extremely gratifying from the point of view of creating a positive self-image and allowing a powerful experience of closeness to other people.

We can identify at least three positive aspects to the combat experience. To understand the first, a sense of competence, it must be noted that the average age of Viet Nam combat soldiers was 19. Young men went in a matter of months from the uncomfortable status of late adolescence to a situation in which they had tremendous responsibility, frequently operating equipment worth millions of dollars, and making decisions and taking actions which had life and death consequences for themselves and others. For many, their performance in Viet Nam was by far the most intense experience of competence and mastery of their lives, and the awareness that they are unlikely to be so effective again is a definite part of the PTSD syndrome.

The second positive aspect was the closeness that developed from living with a small squad of men in the combat situation, dependent on each other for their very lives 24 hours a day. This closeness is apparently unrivaled by anything we experience in civilian life, including falling in love. The almost complete social isolation experienced since the war by so many of these men is that much more painful by comparison. In passing, I might mention that this seems to be one of the major differences between Viet Nam veterans and World War II veterans. The damage to the personality of the combat experience seems to be ameliorated by the group support provided by the VFW and other traditional veterans' organizations. For a variety of reasons these organizations were not perceived as available to or supportive of Viet Nam veterans.

Finally, the experience of overcoming almost impossible odds through extraordinary individual and group effort was a major source of pride and satisfaction in the combat situation, which again can be contrasted to the repeated failures in all aspects of life since Viet Nam experienced by most of our patients. It is ironic that although the PTSD syndrome is *caused* primarily by the traumatic aspects of combat, it seems to be *maintained* in part by this contrast between the frustrations and disappointments of life since Viet Nam and the positive aspects of the combat experiences. Since there is so little gratification in daily life, there is the tendency to dwell in the intensity of the combat experience.

In previous wars the horror and destruction was accepted by the nation and the soldiers as an unfortunate but necessary occurrence, justifiable because of the overall good purpose of the war. Because of the particular conditions that existed surrounding the Viet Nam war, the soldiers returned to an experience of rejection and hostility from the nation as a whole. The soldier's themselves by and large felt that they had taken part in a vast mistake, and the attitude of the nation served to further reinforce their sense of guilt, horror, and meaninglessness. The result was that the positive aspects of the combat experience were rejected and devalued along with the rest, and veterans were unable to come to terms with the destruction they had been part of or to derive satisfaction from their achievements. The unrelieved negativity of the war experience combined with the continued defeats of life since then account for the despair, symptomatology, high rates of suicide, and so on that we observe in this population today.

Outward Bound can potentially achieve a therapeutic effect by creating conditions that allow the veterans to reexperience these positive aspects of combat in the absence of the death and destruction that traumatized them. A small group of men go on a four day wilderness expedition which is designed to force them to utilize all of their personal resources, as well as creating the necessity to rely on the group for survival and success. Successfull completion of the course should evoke a sense of mastery and competence as well as feelings of being close to and trusting the other men, reawakening in the present the intensity of the positive aspects of combat they experienced years ago. It is hoped that this experience will aid in coming to terms with and setting aside the traumatic aspects of combat while retaining and further developing the remarkable personal resources that allowed these men to survive and function so well in such adverse circumstances.

The above analysis is based on clinical experience and the theoretical undestanding of PTSD that is being developed on the Northampton stress unit. Clearly it is very difficult to prove these assertions or measure in any rigorous way the benefit of a brief therapeutic experience such as Outward Bound. Nevertheless, at this point in time we have had the opportunity to send three groups of seven men each on a four day Outward Bound expedition, totalling 21 men. Our clinical observations have dramatically confirmed the value of this experience for many of the men. To try to convey some of our reasons for believing this, I will proceed by describing a little bit about the men who have gone on the expeditions, and what happened when they returned.

Nearly all the men had been exposed to very heavy combat. Some had experienced conditions not unlike combat in other wars, others had been exposed to a great deal of guerilla activity, terrorist attacks, and atrocities committed by the enemy against their own population and against American soldiers. Those who were exposed to these sorts of experiences often have histories of having been involved in atrocities and indiscriminate killing themselves, though this is by no means universal. The factors all the men had in common are the exposure to massive death and destruction, and having been an active part of the destruction in one way or another.

Lifestyles since Viet Nam vary tremendously. Some men pursued active criminal careers. Many isolated themselves for prolonged periods, some even retiring to remote wilderness areas and staying away from people altogether. Many were married almost immediately after their return, apparently in an attempt to establish some normalcy in their lives, but only a few of those marriages survived. Some had very stable family lives and succeeded in working more or less steadily, though the majority have had numerous short-term low level jobs. Many have had serious problems with alcohol or drugs, some have not. Whatever the combat experience, and whatever lifestyle each individual has pursued since Viet Nam, our experience is that the vast majority have no evidence of having had problems prior to Viet Nam, and they all have had very serious problems in all areas of life since their return.

On returning from the Outward Bound experience, all the men without exception seemed profoundly moved. Many spoke in terms of renewed self-confidence, a feeling of having achieved something, and spontaneously observed that they hadn't felt like that since Viet Nam. And many spoke of the sense of closeness to the other men, of being able to trust and rely on someone else for the first time since being in combat. A number of the men would become quite openly tearful and emotional when discussing the sense of closeness. To understand how remarkable this was, it is necessary to understand both the rigid rejection of displays of weakness and emotionality which are normative in combat veterans, and the extreme subjective difficulty in experiencing emotions of caring and closeness that accompany this quality we call "emotional numbing." At least for some period of time after their return, most of the participants experienced a marked relief from their numbed out state, which they subjectively found to be an event of major importance in their lives.

The habits of 10 or 15 years die hard, and we are not trying to suggest that Outward Bound is a miraculous cure. As the days and weeks go by, the men tend to slip back into their patterns of isolation, depression, and so on, and the intensity of Outward Bound itself becomes another memory. Yet we have observed that many of the men are far more accessible to meaningful psychotherapy thereafter, and we are of the opinion that this one dramatic experience of a crack in the armor they have built up over the years will continue to have a beneficial effect in the future for a significant number of the participants.

Around the nation there are many thousands of Viet Nam veterans who are becoming more discouraged and desperate each day, as they feel their lives slipping away with no sign of an improvement in their problems. Even those who seek help and encounter a program such as ours are proving to be extraordinarily difficult to help, which is related to the extreme severity of the psychological problems that can result from combat as well as the amount of time that has

. MEDICAL CENTER NORTHAMPTON, MA 0106

Veterans
Administration

In Reply Refer To:

elapsed since the trauma. Based on these first Outward Bound expeditions, we are very interested in expanding the availability of this program to Viet Nam veterans. With added numbers we can also plan on mounting a research project to document the beneficial effects of this experience in the Viet Nam veteran population. If the value of Outward Bound were objectively demonstrated, then there may be some hope of creating a nation-wide program that could reach thousands of veterans. The initial hurdle remains obtaining the resources to continue to develop and study this treatment modality.

Bruce I. Goderez, MD

Bruce I. Goderez, M.D.
Psychiatrist
Post-Traumatic Stress Unit

• MEDICAL CENTER NORTHAMPTON, MA 0106

Veterans
Administration

September 14, 1984

In Reply Refer To:

Bob Rhealt
Hurrican Island Outward Bound School
PO Box 429
Rockland, MA 04841

Dear Bob:

I would like to express again my appreciation for your allowing me to become a part of the recent Outward Bound trip with veterans here on the PTSD ward at the Northampton VAMC. The experience touched me personally in a number of ways and gave me valuable insights as to how I might work more effectively with Vietnam vets in my role as staff psychologist. From my hard-won experience, I'd like to share my sense of how Outward Bound carries over to the balance of treatment here on the inpatient unit. First of all, the experience seems to crack the surface and brings the vet to within reach of the rest of us working back at the hospital. Breakthroughs will occur on O.B. which may not be apparent back here until weeks later. When questioned about a major change, vets will credit something that happened on O.B. What happens on the trails, ropes and cliffs out there becomes a catalyst for movement and change back here. The shared obstacles serve to recreate the closeness of the patrol or unit and draws deeply upon the sense of responsibility felt towards each other in the intensity of the combat experience. This sense of responsibility and commitment to others can then be enlarged upon in the hospital setting. The very power and immediacy of the challenges faced in the course, along with the sense of group support fostered by OB leaders, pushes the men past points of numbness and blockage where they come face-to-face with their own emotional intensity. The men take a good look at the flip side of their "fuck it" responses and engage their emotions directly. It strikes me also that OB provides the men with a symbol they can believe in. A dilemma in treating PTSD is that the sense of exploitation and betrayal by their country, itself, has left men bereft of many of the symbols that play deeply to the human psyche and are essential vehicles for healing. Finding something to believe in is a difficult and painful process. The scrap of cotton begins to fill an empty place.

As you mentioned, each trip is very different. If I went with a different group or at a different time, this letter might be also different. The thread I see, though, through the six trips taken from this ward is a much-needed affirmation of self and an awakening of the sense of possibility that one can, in fact, change his life; he can do things he thought impossible. There is a liveliness and a reawakening of a capacity to genuinely struggle as opposed to going along with hospital routines in a vague hope that things will somehow get better.

Good luck in your efforts to expand OB to other programs working with veterans. As a staff, we consider the contribution from Outward Bound to be the single most powerful tool in the program. Thank you for all your help.

Sincerely,

Richard C Pearlstein

RICHARD C. PEARLSTEIN, Ph.D.
Clinical Psychologist

SUBJECT: "OUTWARD BOUND" EXPERIENCE WITH VIETNAM VETERANS

TO: BOB RHEAULT, HURRICANE ISLAND OUTWARD BOUND SCHOOL

FROM: POST-TRAUMATIC STRESS TREATMENT (PTST) PROGRAM DIRECTOR
AMERICAN LAKE VA MEDICAL CENTER, TACOMA WASHINGTON

I. I am taking this opportunity to provide some feedback about the very,very positive outward bound experiences completed by patients and staff from our PTST Program. Overall, we found the experiences to have profound, positive impact on group cohesion, trust, confidence, team building, ability to enjoy, and willingness to engage even more in dealing with war-related issues. It will be a terrible loss to future groups of patients, in terms of their stress recovery from war-related traumatic experiences, if funding is not found to allow continuation of the outward bound experience.

II. BACKGROUND:

The Northwest PTST Program, at the American Lake VA Medical Center, in Tacoma, Washington, was established in April, 1985. We operate a 31-bed in-patient and substantial pre-bed and after-care treatment program for male and female veterans of any era whose recent and current difficulties appear to be at least partly connected to unresolved traumatic issues from their war experiences, i.e., survival guilt, intrusive and recurrent symptoms, numbing, isolation, hyperarousal symptoms, rage and/or other related symptoms. Vets are admitted in groups of 12, and go through the 11-week rehabilitation in-patient phase together. An integral component of the stress recovery process is the bonding together and establishment of trust relationships with each other, and with the veteran and non-veteran staff; such bonding is essential in order for any meaningful progress to begin regarding sensitive war-related issues.

Our PTST Program had an opportunity, with a one-time availability of some funds from the Readjustment Counseling Service (Vet Center Program), in V.A. Central Office, to develop and finalize a contract with the Pacific Crest Outward Bound School in Portland, Oregon. In addition to the provision of 11, one-day "rope/height challenge" courses, we had two groups of vets (11 on each course) participate in a 3-day and 6-day river/climbing course,respectively. The feedback I will provide in this letter is about the 3-day and 6-day courses, each of which also was participated in by two of our PTST staff.

III. BRIEF DESCRIPTION OF VETERANS PARTICIPATING:

All of the veterans who participated in the two river/climbing courses were Vietnam veterans, almost all between the ages of 36 and 42; there also was one Korean war veteran, in his mid-fifties, who had serious pulmonary/breathing difficulties. All of the veterans had been in at least several other treatment programs (in-patient and/or out-patient) prior to entering our program, and for at least several years had been having serious difficulties with post-traumatic stress symptoms and other related problems, including substance abuse, isolation, rage and/or depression symptoms, etc. Early in our treatment program, as is typical, there was significant mistrust of all staff, and both mistrust and fear of getting too close to the other veteran patients in the group. The 3-day course was planned to occur in the third week (out of a total of 11-weeks in-patient stay); it was hoped that the experience would have a favorable impact on group cohesion/trust issues, as well as on confidence, team-building and other parameters as well. The results were overwhelmingly positive. The 6-day course included 11 veterans who had already graduated from the 11-week rehabilitation program (at different times); it was hoped that the experience would facilitate after-care issues and stress recovery progress. Again, the results were amazingly powerful.

To protect anonymity of the participating veterans, first names only are used in the next section, and only particularly noteworthy physical disabilities are mentioned. Practically all of the veterans were not in good shape physically, and were enthusiastic about going on the course, as well as somewhat concerned about their abilities to complete and enjoy the experience. Excerpts of actual feedback from several of the veterans have been included, both from the 3-day and 6-day courses, respectively.

IV. COMMENTS BY PARTICIPATING VETERANS ABOUT THE OUTWARD BOUND EXPERIENCE:

Tony (57 year old Korean vet with chronic obstructive lung disease that severely restricts physical activities): This trip restored my confidence in myself as a man. I feel now that I still got it -- I was feeling real sad for myself for a real long time (30-year substance abuser). The trip relaxed a lot of my stress; in fact, my sleep on the trip was remarkable -- hadn't slept that well in decades. The highlights for me were: (1) the thrill of going through the rapids; (2) my physical stamina -- it was there!. That paddling -- maybe I can go back to work again. I now want to go back to sea. I'm a seaman -- always have been, but stayed from it all these years.

> Feedback to Tony from another vet (Ron): I really got closer to you in the three days there -- much more than in the previous three weeks here on the ward. You were just a "yes" man before the river trip -- but now, you are working for you...

Cal (chronic lower back pain and degenerative disc disease): My leg "went out" there is the boat (e.g., painfully"locked up") -- I was really impressed how people helped me at that time. I'm very afraid of the water; I have a great fear of drowning. I found out a lot about myself -- when I was made boat Captain, I initially was glad, but then I didn't like the responsibility for others. But, I had a good time, made myself do things I was real afraid of doing... I really loved coming down that rock (rappelling)-- I haven't done that since active duty (when Cal was a climbing instructor). It was a fantastic feeling coming down that rock -- I'm going to do it again!

Feedback to Cal from another vet (Ron): Since O.B. I think you've opened up a whole lot -- you're really a nice guy coming out now; I liked you a lot -- before, you were very distant and reserved. Cal: I must admit that I did keep some control by staying at the rudder in the rear of the boat when I wasn't Captain -- and not sitting in the middle or front of the boat. After seeing people afraid on the rock, I was then willing to admit my fear of the water.

George: I enjoyed all of it -- the only problem was with the plastic bags used for storing gear -- reminded me of the many body bags that I filled in Nam. However, I found peace within myself on this trip -- the first time since Nam. I really enjoyed being around you guys -- usually, I go by myself or only with my wife, to get away. I've learned to enjoy myself again! (note: before the trip, George almost never smiled, was very serious and withdrawn; afterwards, the beaming of his face and eyes was a remarkable contrast to before).

Ron: I had a lot of issues come up for me on the trip -- trust, confidence, fear, willingness to take responsibility -- like Anne, then Dick, making me be the boat Captain -- I had been hiding from it; then, after doing it, I started trusting myself again, for the first time in a long, long time. When we got to the rock (60 feet high), I said to myself that I got to go first; I kept saying "I can," "I can" - not, "I can't," "I can't.- my blood pressure is hurting me, etc. No, I said, "I could." It was like a magic pill -- I can now say that *I can do it now* -- and I still have that confidence."

Feedback from another vet: You were on that ole pitty pot before the trip -- poor me, poor that; now you've done a great reversal. Another feedback: you've finally come out of your depression."

Ron again: It also was fun to tell Anne and Ray (PTST staff who went on the trip as participants) what to do. And, I got past being worthless -- my wife this past weekend said I wasn't "Mr. Negative" anymore -- so I am carrying some of it with me.

Dennis (wheel-chair bound, above-the-knee amputee): I had to depend on people, and had to trust them, and I have a great fear of drowning. I didn't want to depend on people, having people pushing me around in my wheelchair (some of the terrain was rough, and Dennis was unable to move himself as he usually does). I found that I could depend on others; we were really working *as a team* by the third day. All in all,I now feel that I can go *anywhere* if I'm willing to let others help!

Bill: The first day, I was very wet and cold, I was miserable. The second day, I started enjoying; I really got off on going down the rock, once I got past the hump. On the third day, that was the most enjoyable. I'm a bird freak, though not that knowledgeable. I really focused on the nature around me (as we were rafting down the river, in-between the rapids). Sharing our observations about the beautiful nature around us brought me and the group really close together. I had the best sleep I have had in three weeks; I drank no coffee, and didn't seem to need it. The river brought back memories of fear in Vietnam; and the river/fear did bring up one Vietnam experience that I had not realized was a problem before; now, I need to work on it....(Note: and Bill *did* work in Vietnam focus group quite successfully on a traumatic war experience on the river).

NOTE: The following comments are from vets who were outpatients (graduates of the 11-week program) who went on the 6-day trip; several group members did comment about being depressed for the first three or so days back. It is important to note that on this trip, one boat did capsize in a very turbulent rapid, and there were 10-15 minutes of great fear, concern, confusion, etc., for both the vets in the capsized boat (several of whom were thrown overboard and carried a distance downstream); and for vets on the other boat, which went through the rapid first, and who were involved in observing and "rescuing" the first boat's crew from the waters.

Mike (below-the-knee amputee): For the first time in a long time, I had a taste of fear for others, and for myself. I became acutely aware of my physical limitations. My stress level went up and I wanted out; yet, I accomplished what had to be done. Everything was totally out of control, I was very frightened, and still I did my job totally well. I went through so many changes....Most positive for me was the discovery that in the middle of rushing water, you can hit an eddy (a stretch of "quiet" water off to the side), and just sit safely, and I *can* do that in my life, too! Also, that you face your boat *towards* the danger and backpaddle -- rather than closing my eyes and going for it -- that gets me in trouble!

Leroy (below-the-knee amputee): I felt such joy -- one time I looked over at Doug, and he was *so* full of life, and yelling. He then said to me, "I'm charged; I wouldn't change this for anything." And *I* felt *really* happy to see that man that I love so much finally be so happy...I also remember the helplessness and anger when the boat overturned; I ended up downstream from the (overturned) boat, and was unable to help the others in my boat (Leroy was the boat Captain at this time). And that's a big issue for me, back in Nam with my patrol.....The most positive thing about this experience for me is that now I really feel confident about where I'm going and what I'm going to do with my life. I'm ready to start to say no; I'm going to take a leadership role in my life. On this raft trip as Captain, I felt able to go scout the rapids, felt real close to and let someone else help me when I needed help. I deserve a break in life -- I'm tired the way I live....

David (partial hemiplegic -- ambulatory, but significantly paralyzed on the left side from a Vietnam head trauma): What stood out for me was the constant reassurance from the O.B. staff, and the feeling of security I got from that. I got a real real serene feeling on the trip (something I almost never have). I also was in the hot seat in the evening debriefing/rap group sessions -- partially because I was willing to just honestly say what I felt -- without my usual staying in my head for 20 minutes or so! I got a lot to brag about from the trip, and to tell my son about -- I did it! I jumped off that rock with that rope tied around my ass; I pulled my load in the boat. My successes there really stand out for me. And to be honest, I haven't had too many other good times in my life since Nam to talk to my son about. It was a great trip.

Dennis: What a f_ _____ rush -- I've never felt anything like this since Nam! Fast action, fear, panic, speed -- all I hear(from the other guys talking about their perceptions about what happened when the boat overturned) is all these missing parts that I could not remember. That makes me think about Nam -- what do I remember about what really happened in Nam? What I'm not remembering now about the experience -- will it come back to me later? I saw it totally differently than Dave did -- he said he enjoyed it, and I saw him full of fear and panic, fighting us (when he went overboard) -- what's the reality? Speaking of positives, Paul (O.B. staff) said the river's a metaphor for life -- and it is; I need to spend more time in the woods, need to integrate that again more into my life. I also let a couple of people into my life on this trip -- Kurt and Mike -- and that's a pretty big step for me --entails some responsibility -- found out some other people in my life are good, and important -- haven't had that for 17 years... And Mike's disability (below-the-knee amputee) was a real eye-opener, how your disability affects you. I see stress there that I didn't see before, and I feel real good that you, Mike, let me into that.

Kurt: Yeah, I am looking for that big eddy in my life. Some of that serenity, that peacefullness I felt in that wilderness area, and around men -- I am going to try that with my wife -- hopefully, there will be a connection between us, some kind of softness in me, within male-female relationship -- that would be real nice....

Doug: I try not to be so negative about something I accomplished, like a fear, and not let it swarm over me like it usually does -- and I can let it happen. I do have some power to fight it now, I experienced that on this trip (Doug has had numerous panic attacks for several years). And, I also get strength from others -- and on the raft, with some help in some decisions, I did have some control over my life! And I helped overlook others as well as them overlooking me -- and that felt really good! I did find some peace and serenity out there -- and I want to have it with my family, also....

V. COMMENTS BY PTST PROGRAM STAFF WHO PARTICIPATED:

Anne Gregory, R.N. (nurse manager, and Vietnam veteran): White water rafting had always been a vague future dream that I wanted to do in my lifetime. This trip presented an excellent opportunity to learn how to handle myself in an occassionally terrifying and exhilarating experience. As a woman, it opened my eyes to my dependency traits and I learned to be "one of the boys" and do everything including going down that rock. At the end of the three days, I felt as though I had tapped into some unrecognized personal inner resources and that I could now just about do anything I set my sights on...For the patients, this trip showed another side to the staff -- the human side. We helped each other packing gear, cooking and setting up camp. They learned that we were not all powerful. The natural leadership and competency/abilities came through in some, and to see the smiles on those exhausted faces at the end of the day made me feel that it was all worthwhile....

Tom Olsen, R.N. (Vietnam veteran); and staff nurse: What stands out for me was how I reacted when I pulled Dave (partial hemiplegic) from the water and into the boat -- I saw the total fear and helplessness in his eyes; I said, "you're safe, and I'm going to get others into the boat." I was shocked that I could act so fast! I saw the string of guys in the water, with not enough rope for everyone -- and it was like (in Nam) looking down the hall in the hospital at the rows of gurnies, full of men...

Feedback from vets: Tom I was really impressed at how much you were willing to confront others when they needed it, you were much more assertive than I've seen you on the ward!

Tom: The most positive things for me about the trip were trying new challenges, taking new risks, being close to people -- all was real rewarding; and, like the river, don't be afraid of it -- go up to it, face it, use the power of the water, don't struggle to compete with it all the time (on the river, or in life -- including dealing with PTSD).

Ray Scurfield, DSW (Vietnam veteran) and program director: I was scared out of my mind up on that rock; heights are the one thing I really fear in life. And several of us were up there, so scared, and trying to get it up to go over the edge. We were in it together, the shared fear experience really bonded several of us, and I was also willing to show my fear (it would have been hard to hide it, anyway!). I experienced the river as wonderful, and felt an incredible sense of togetherness and peace and happiness floating down, paddling together, learning to be a real team, appreciating and sharing the beauty around us, and enjoying the moment! The river really is a life metaphor -- especially how to reach an eddy in the middle of turbulence, learning to flow with the current's force, how to scout and ride the rapids. I am amazed at the incredible experiences that I experienced and saw in others, of absolute joy, excitement, accomplishment, togetherness, fear, anger, exhaustion, strength, confidence-building, and sharing and caring for each other. And, going as "just another vet" (with the O.B. staff as"the staff") was really a marvelous, humbling and challenging experience for me, and for the other vets (the trust lines, and expressed love and caring, happened to such an extent that just can not possibly occur in the hospital setting alone -- and all of us were much better off for that...)

Art Owens, Mental Health Associate (Vietnam veteran): Personally, the O.B. experience gave me an opportunity to re-experience many positive skills I've acquired from the military. I had not paid much attention to comradeship, teamwork, personal challenges and achievement of my survival skills and a close friendship with vets and other people in my life. It reaffirmed that what I learned in Vietnam was worth remembering.

For the other vets, I saw changes in attitudes toward connecting their individual experiences with present issues in their lives. I witnessed their bonding to each other that goes deeper than mere teamwork and friendship,which allowed them to share intimate feelings with the O.B. staff. As a PTST staff person, the vets shared sensitive issues with me and were much more open to alternative resolutions than in the past. I truly cherish their faith and trust for me,and the O.B. experience made all this possible.

The changes in one vet in particular stand out for me. Prior to the trip, Larry was one of a few Asian/Americans to go through the program, and he was also not well connected with vets in general. He always secured a buffer zone between himself and non-Asian vets. On this O.B. trip, Larry blossomed into bonding real well with the O.B. staff and the other vets. He appeared to be enjoying a different perspective on non-Asian vets and he acknowledged this to them during our evening group debriefing/rap sessions. He especially developed a close relationship with one vet and one O.B. staff. Larry was smiling and joking with the whole group at the end of the trip (a remarkable contrast to his normal demeanor). He also made a commitment to expanding his outlook on nature and keeping in touch with each vet on the trip. I witnessed such growth in his personality that I'm certain the O.B. program was the crown (and I have been following Larry in an after-care group for these past four months following the O.B. trip); O.B. was the crowning tool he needed to open his mind to other emotions and feelings other than withdrawel and avoidance. I saw him finally being aware of enjoying himself with vets that's 180 degrees different than what he experienced in Vietnam, or since....

CONCLUDING REMARKS:

The overnight O.B. experiences were, simply, remarkable -- remarkable both in terms of the impact on the group as a whole, and on the individuals who participated. The group bonding and cohesion was not only dramatically accelerated in the amount of time it took to occur, it also was dramatically accelerated in quality and extent above and beyond that ever achieved by any other group in the program. The results were demonstrated in the very significant therapeutic achievements in subsequent group therapy sessions. In addition, the specific impact on individuals and their own unique issues is reflected in the veterans' own comments as noted previously. The willingness and ability to uncover issues, face them, provide constructive feedback to each other, care about each other, and achieving new levels of resolution, was truly noteworthy. And, last but certainly not least, the socialization impact both during and following the program, on veterans whose isolated life-styles were quite pronounced, was significant. All in all, I cannot imagine a more positively impactful dollar-for-dollar component to a PTSD rehabilitation program than an Outward Bound-type experience similar to what we were fortunate to have in 1987.

Should anyone wish to discuss any aspects of our O.B. experience (either or both the one-day challenge courses and the overnight courses), please do not hesitate to contact our O.B. Coordinator, James Burke, P.A., or myself.(206) 582-8440, ext. 6151, 6155 or FTS 396-6151 or 6155.

RaM Scurfield

Raymond M. Scurfield, D.S.W., L.C.S.W.

APPENDIX B

EXTRACTS FROM LETTERS FROM VETERANS

ALUMNI OF OUTWARD BOUND COURSES

"The memories of the climb up that mountain are some of the most severe of my life, but the friendships and camaraderie were the best. I now have 4 boys (we just took in a nephew) —— I would like the older boys to go on Outward Bound; it would be great for them. ———"

George McK. HV-03 1984

"The memories of those few days together on the mountain will always be with me and remembered with pride."

Roger B. HV-01 1983

"There was so much I was missing before I went on Outward Bound, like I learned how to get closer to people, to trust them - —— and it's brought me closer to my family. I've had a major turnover in my life since. Folks don't realize what they're missing in this world ——— It was just what I needed. Also to realize that I was not alone; it was tough to let the walls down and let someone in, but the feeling when I did was one of great warmth inside, where I've been so cold all these years. I would like to thank you ———"

Pat E. HV-21 1986

"As for myself I'm doing pretty well. I will always remember our Outward Bound experience. It was a hell of a good time even considering Hurricane Gloria. I'm still an outpatient at the V.A. but I'm doing well coping with life. I have a nice apartment and girlfriend which I've been seeing now for almost two years. I'll be proud to put the new patch in my wall plaque with the rest of my medals.

Norman C. HV-13 1985

"I am doing fine and use what I can from the Outward Bound experience."

Steve LaM. HV-21 1986

"Thanks for that trip up Moosilauke. As I said before, it was second only to one."

Rick S. HV-16 1986

"—— Currently I am doing fairly well. On occasion I have a difficult time, but always seem to bounce back. I feel that I am a fighter and a survivor in this life and will somehow overcome obstacles that come in my way. ——"

Ed W. HV-09 1985

"I have thought often of our time in the mountains. I think of the situation that I was in at the time. Things are going so well for me now.

I work at Amherst College; it's a good job ——

If you remember, I was a little down on our first night out, because I was carrying about my son, and we had that talk. Well we're doing great together; I can really relate to him and we are very close.

I'm in great physical shape and work out at the college -- nautilus, weight room and swim ——

I think about our trip often; it has added to my new found skills —— still haven't had a drink for 2 years and 9 months. ——"

Steve S. HV-10 1985

"—— We talked and talked about Vietnam and mostly about how Outward Bound has helped so many of us come home, at least a good start. I will never forget my experience with Outward Bound or the guys that spent that time with me. I am proud to know that I have gone back to college and am taking some traits with me from Outward Bound. Not to put down the treatment I received from the PTSD program, but without Outward Bound, there is no PTSD program, and I'm sure many Vietnam vets feel the way I do. ____ I owe Outward Bound for giving me new spirit and pride ——"

Jerry S. HV-18 1986

"—— I often think about the things I did out there that I never would have had a chance to do if not for you and the Outward Bound team. I know my leg is bad, but I did it anyway; that was and is still a good feeling — determination to go on now with my life -- thoughts of the Outward Bound trip and the help of the PTSD Unit here at the hospital — I can give a damn good fight back at my problem. I am doing and feeling good.

Ulysses R. HV-22H 1986

"A perspective of time has not altered a bit my sense of accomplishment with which I came home from the Moosilauke Outward Bound excursion. I felt a double sense of achievement: one because I humped my pack up and down the White Mountains like everyone else, and two because as a therapist I was there to observe the healing effects of the physical challenge, the comradeship and the self-trust that evolved among the veterans I'd been working with at the hospital.

The Outward Bound Program dove-tails very nicely with the therapeutic goals established in the clinical groups on the ward. For one thing the very physical nature of the challenge is appropriate medium for physical men to work through in a practical way some of their anxieties. The hike is strenuous, and the pride of accomplishment is proportionate to the exertion. The excursion similarly requires cooperation among the men in order to reach such basic objectives as the campsite, or to pitch camp or cook dinner.

Further, the trust that begins to develop among the group is cemented — or was on my trip — on the ropes events and particularly on the rock climbing, during both of which fear is a prominent emotion. My sense is that many of these veterans had in combat been scared beyond belief, so that they were forever afterward unable to trust the world, other people or themselves. On the Outward Bound trip; we had a group of exceptionally mistrustful, anxious men confronting their limiting emotions in strategic, rewarding and memorable ways, and as a result, they extended the range of their behaviors.

I'm doubly grateful that I was able to participate in the Outward Bound program, and that I was able to meet you."

Brad C. HV-20 1986
VA Staff Psychologist

"I was just going over my papers, pictures, etc. of Northampton and times past.

My family and I are doing well considering the years of my behavior patterns and substance abuse.

I am taking things one day at a time and am proud to say that I have been alcohol and drug free going on 3 years. I have my struggling days and weeks but I am able to cope with the pressures of life much more easily with the support of my family and people like yourself. Thanks for being you, Col. Bob and allowing me to be a part of the journey you are taking in helping us Nam Vets. Keep it up! You have made a difference. I think of our Moosilauke venture often.

Joe O. HV-07 1985

"—— After our trip together, I was released from the hospital back home to Manchester where I've been seeing the doctor on an outpatient basis. Cindy and I started doing stained glass together. It was the confidence I gained from you and the others to get going with something in my life besides dwelling on Vietnam 24 hours a day. To be honest, I still have my moments, but I can control them better when I think back to our campfire rap sessions. —— I want to go back to school to get a degree in the paralegal field and also start a business with Cindy in stained glass as a part time income while attending school. —— We've been closer in the past few months, more than our 14 years of marriage. This was due to your help in being able to put the war behind me. —— I'll never forget it, as we talked about, but I'll never let it dominate my life or my families' life again."

Chip S. HV-20 1986

"—— I have in the past 2 years kept up the Hurricane motto. I will serve, strive and not yield as long as my body will let me. ——"

James M. HV-07 1985

"—— I remember the companionship, the trust of others. I am trying to keep it together. I was watching 60 Minutes and was glad to see another group of women on Outward Bound. It gives me hope to keep trying. ——"

Dave M. HV-21 1986

"—— I'm doing OK. Still seeing Dr. Rodriguez at Lincoln Street. I have both good and bad days but when I get really down, I take out the pictures of our struggle up Moosilauke. The pictures and the memories really help me get out of it."

Bill B. HV-07 1985

"Outward Bound — I think what stays up front in my mind is the sharing ——— I loved the bonding that came about, even though for the first 24 hours it looked like an impossibility that we would come together. I thought we shared some pretty heavy duty stuff because by participation we were leaving ourselves vulnerable on every front, yet we quickly developed trust that enabled us to try and try again. That trust allowed us to give and receive on a mutual basis. It really felt good. It was really reminiscent of Nam. I was truly amazed at how Dave and Mike kept it together - they were nothing short of remarkable. I'll never forget the guys. I think that we all gave a little extra of ourselves when it was needed most."

"Today the Outward Bound experience is still alive within me. I easily relive it when I see the video. I think its done one thing in particular for me and that is I dare to try more things today."

Tom D. HV-21 1986

"It made my day to receive your card, I think of our time out in the bush and on the different courses often. You can't imagine how much it helped me.

But the thing that made an everlasting change in my life was talking and listening to you. Bob, I was always ashamed of what I did in Nam. You made me for the first time since being back feel some pride in serving my country and in my self for doing what we had to do to stay alive.

Its a great thing not to be ashamed anymore, and I can not thank you enough.

I'm still working on myself and trying to change the way I feel about things I cannot change.

I saw you in the D.A.V. magazine and look for articles in the Outward Bound paper about your work.

One of my sons really needs help, he is into drugs and booze, has a very low self-esteem and could use a course in Outward Bound. Hopefully in the near future, I will be able to afford to send him.

I want to thank you again, Bob, you are one in a million. I wish you all the best life has to offer."

Joe M. HV-05 1984

"I am feeling optomistic about my immediate future as I have worked very hard in the program and have gained much insight and touched many feelings and issues. This program is by no means easy, but if approached properly, there is alot one can derive from it.

As for my Outward Bound adventure, I was somewhat disappointed to hear that you would not be going (Sept.). Mike Heaney and Dave Nazzaroff had a rather difficult group on their hands. They got the job done and changed us as a group. I can't say enough about them and they made a deep impression on me. Outward Bound brought out the old Artie in me, I'm still there. All that's been lost is time, but God willing, I can make up for that lost time in my future. I pan on leaving Ward 8 by the front door with my head held high and use my experience here for when I feel low and weak. I'm truly grateful for the program, for this is all there is for us guys."

Arthur M. HV-21 1986

"--- I think about Moosilauke all the time. I still wonder how I made it up that hill. That was one of the best times of my life; it is in my mind all the time even when we were back on the ward.

I used to go to the cliff (rock climbing area we use during OB Vets courses) by myself and sit at the top and think.

Bob F. (another Vet) and I had some trouble with each other, but that little walk in the woods took care of that. As you well know, if it wasn't for Bob F., I would never have made it up that cliff."

Dennis W. HV-13 1985

"Things here with me are fine. I still have my ups and downs. Since going through the PTSD program, my life has improved. I still go back each week for therapy. Some days are harder to face than others. But I am going on with a positive attitude. After almost 18 years getting numbed out, I have a lot of catching up to do.

Being able to be part of the Outward Bound troop has been a real gift of pleasurable experiences, which I will always remember."

Frank R. HV-18 1986

"I can only say that however late after completing the Outward Bound course and applying the confidence that you and the course itself instill in me did, I apply it to a positive way of living. I feel I am serving, I am striving, and not yielding and by "taking one step at a time", I can't help but rise and take my place among the 'winners'."

Dwight F. HV-05 1984

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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON THE

POST-TRAUMATIC STRESS DISORDER

PRESENTED BY

STEVEN SONNENBERG, M.D.

BEFORE THE

SENATE VETERANS' AFFAIRS COMMITTEE

JULY 14, 1988

Mr. Chairman and distinguished Members of the Committee:

I am Stephen Sonnenberg, M.D.. I am in the private practice of psychiatry in Washington D.C. and am testifying today on behalf of the American Psychiatric Association, a medical specialty society representing over 34,000 psychiatrists nationwide, to share our concerns about the provision of appropriate psychiatric and psychological services to veterans with Post-traumatic Stress Disorder (PTSD) particularly, Vietnam Veterans. PTSD is a recognized psychiatric disorder and included in the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM III-R).

I am a Clinical Associate Professor of Psychiatry at the Medical School of the Uniformed Services University of the Health Sciences, Bethesda, Maryland, and Distinguised Visiting Professor of Psychiatry at Wilford Hall USAF Medical Center, San Antonio, Texas. Wilford Hall is a teaching hospital of the Uniformed Services University of the Health Services. I was formerly CO-Director of the Medical Legal Clinic of the National Veterans Law Center, working side-by-side with the legal staff to help Vietnam Veterans who suffer from Stress Disorders stemming from their Vietnam combat experiences. I also Chaired the Committee on Federal Government Health Services of the American Psychiatric Association, and was Senior Editor of the book The Trauma of War: Stress and Recovery in Vietnam Veterans (Washington, D.C.: American Psychiatric Press, 1985). Most recently I was the Director of Research at the Project on the Vietnam Generation, which was affiliated with the National Museum of American History, at the Smithsonian Institution and I currently sit on the APA's Joint Commission on Public Affairs.

The American Psychiatric Association remains concerned with the plight of the Vietnam Veterans, and the need to develop and evaluate appropriate mental health treatment programs. To this end, during the early 1980s, the APA mandated the Association's Committee on Federal Government Health Services to study those Vietnam Veterans participating in various Veterans Administration treatment programs, as well as the treatment provided. This Committee's composition was impressive: its members included the Chair of the Department of Psychiatry at the Uniformed Services University of the Health Sciences; the Associate Director for Psychiatry, Veterans Administration Mental Health and Behavioral Science Service; and outside consultants such as Drs. Egendorf and Laufer of the Center for Policy Research, from which stemmed a most comprehensive and perceptive study of the psychiatric and psychological needs of Vietnam Veterans. My experience as Chair of the Committee is reflected in the book I mentioned above.

For two decades I have worked intimately with those suffering from the effects of psychological stress, and since 1979 my attention has focused on Vietnam Veterans with PTSD. In sum, I appear here today with a background as a service provider and researcher in the area of psychological stress among Vietnam Veterans; as an individual with a substantial familiarity with the Veterans Administration's psychiatric program for Vietnam Veterans; and as the representative of American psychiatrists concerned with this issue.

Seven years ago I had the privilege of addressing this Committee regarding the Vietnam Veterans Counseling Readjustment Program. At that time I described those who used this program as typically suffering from PTSD. I said they were similar psychologically to World War II concentration camp survivors, or those who survive tragic civilian disasters. In the case of the Vietnam Veterans, the trauma to which they were exposed was guerrilla warfare and, for the most part, those who are most substantially disturbed, participated in or witnessed the worst of death and dying (e.q., the mutilation of a close combat buddy) or survived the ambush of their unit. Because they survived, and feel guilty over survival, they suffer emotionally. At the same time they were further stressed by an unpopular war and other factors.

In the last seven years we psychiatrists have learned much about Post-traumatic Stress Disorder, and a typical Vietnam Veteran who suffers from it. Keep in mind that this condition is seen in others who have suffered severe psychic trauma, and in the past has been known as Shell Shock, Traumatic Neurosis, and the Survivor Syndrome. To begin, the individual suffering from a Stress Disorder is guilty over having survived a disaster, which took the lives of others. The individual may experience clinical depression, with a full range of accompanying symptoms, such as loss of appetite. In addition to insomnia, the individual experiences nightmares of the traumatic event, and in severe cases can experience flashbacks in waking life. These are altered states of consciousness in which the individual believes he is again experiencing the traumatic event. As can be seen from what has so far been described, some experts have noted that much of the individual's psychic life is devoted to re-experiencing the traumatic event, and on an unconscious level the individual hopes to master the trauma, make it come out differently. As the Disorder is so psychologically painful, many of these individuals compound the disorder and self-treat themselves with drugs or alcohol.

Since at the psychological core of the disorder is a fear of loss of loved ones and friends, these individuals keep distant from those around them. Thus, they are often hardly able to function with friends, family and employers. Their divorce rate and unemployment rate are in excess of what would be predicted compared to similar cohorts who have not experienced combat service in Vietnam.

The typical Vietnam Veteran with PTSD saw Vietnam combat in his teens. He was younger than the typical combat soldier of World War II or Korea, and was therefore more psychologically vulnerable than those men. He came from an underprivileged racial or ethic background in greater than expected numbers, given the size of his race or ethnic group in the population at large. He now has, relative to his peers, a history of poor vocational and/or material adjustment, and perhaps alcohol or drug abuse. He reports that his problems began immediately after combat trauma, or that there was a latency period of months to years (which resulted in the name Delayed Stress Reaction), but he will consistently report some combination of the following: guilt over survival, anxiety, depression, nightmares, and altered states of consciousness. He will tell you that he has suffered for long years, was distrustful of the Veterans Administration, and initially did not seek treatment in conventional VA facilities, choosing an Outreach Center, Veteran Administration's storefront.

What we have learned about PTSD in the last seven years confirms what I suspected in 1981, when I previously addressed you. Then, and in various academic presentations and papers, I suggested that PTSD was a condition which might produce and be perpetuated by a basic, fundamental change in the biological and chemical functioning of the brains of those who develop it. There is substantial evidence today that this is so. The condition, then, is now understood as the end result of both biological and psychological factors. This means that biological and psychological predispositions, specific forms of trauma, and ongoing life experiences all converge to produce the clinical picture and course in a given sufferer.

I know that today you have heard reports from various researchers, and are probably feeling inundated by statistics. What I am here to tell you is that for a given Vietnam Veteran with PTSD, or a given Veteran of any war in which America has fought who has PTSD, or even any Veteran who has been psychologically traumatized but does not develop full-blown PTSD, the course of life is unpredictable, and the course of PTSD, if it develops, is unpredictable. But in every case there is no question that exposure to combat produces a very real vulnerability to later psychological difficulties. For that reason, and recognizing fully that we live in a world in which resources are in short supply, but in a nation which sent Veterans to war, in Europe and the Pacific in World War II, and later in Korea and Vietnam, I proffer the view that a full range of excellent treatment options must always be readily available for the men and women who are our Veterans of war.

I shall now focus on the treatment options which specifically involve those with both a full-blown or a part of the PTSD clinical picture.

Those with these conditions may suffer acutely or chronically, consistently or intermittently, or just once in their lives. Some require treatment on an in-patient basis, some as out-patients. Some require concurrent drug and alcohol abuse treatment. Some require extensive community based care after hospitalization, for a range of needs (i.e., drug abuse, family counseling), some require peer group counseling, some need long-term psychopharmacological help, and some long-term in-depth individual psychotherapy.

Vietnam Veterans are approaching mid-life, and that means that special attention must be paid to the confluence of the expected developmental challenges of that period of life, superimposed on an ongoing struggle with the aftermath of psychic trauma. We must be aware, then, that we may find that Vietnam Veterans with PTSD develop more psychological difficulties in mid-life than do their peers. We must be prepared to treat those who so suffer.

Finally, I should add that with PTSD there comes a vulnerability to physical illness, and we must be prepared to diagnose and treat those ailments, without compromise of the highest medical standards.

It is absolutely essential that you know that there are no easy solutions to the problems which I am describing: veterans are vulnerable, and it is our nation's responsibility to treat them. To me this task can only be accomplished if the Veterans Administration is able to provide not only excellent and comprehensive treatment, but conduct excellent training of professionals, and excellent research. As you know, this requires substantial sums of money, which only you can provide. Further, the VA cannot do it alone, and a mental health care system able to meet the challenge of working with the VA must be strong in all regards: there must be excellent practitioners, excellent training, and excellent research. And finally, the active interest of the U.S. Congress, in evaluating and supporting ongoing VA efforts in the areas of treatment, training, and research is essential. You in the Congress represent the will of the American people, and your ongoing and staunch support of the VA, and active exercise of your oversight function are crucial. There are psychological forces which cause us to forget those in psychological pain, and that this pain can be as devastating as any physical pain, if not moreso, and you can help counteract those forces.

Again, I am aware that in a world in which resources are limited we all want to find the most economical way to do what needs to be done. That I am telling you that I know of no short-cuts cannot be a welcome message. But as a very experienced psychiatrist, and a man with great concern for our Veterans of war, I must tell you that PTSD is not a trivial disorder, it can be debilitating and chronic and those of us charged with creating the very best mental health care delivery system need from you all the support and help you can possibly provide. We'll try our best, and we implore you to work with us in that spirit. Let us know of your support, and your concern, as you are today, and continue to give us funds so that we can go on training fine psychiatrists, conducting excellent research, and providing excellent treatment.

In my view the most serious long-term health problems of veterans of war are mental difficulties, when we measure health problems by assessing the numbers who suffer intensely over the years. I do not believe I am talking now about a lesser form of health problem; I do not believe that because the PTSD sufferer is often physically intact, he or she is less impaired than those who were physically wounded. Let me repeat: a mental illness, e.g., PTSD can be as tragic and ravaging as any physical illness. This explains the urgency of my plea.

In sum, the VA has made great strides in treating those with PTSD, and the Congress, by expressing its concern today, has provided a very necessary form of support. That support will assist the VA in continuing its necessary unending efforts in meeting the challenge.

We trust you will concur with our views and provide the support necessary to those who come before you in these hearings as federal government health care providers. Those individuals have on several occasions provided you with valuable information about PTSD, and the specially tailored programs they run. I believe their efforts and the techniques they have developed, and will develop, will prove to be a lasting legacy to our nation.

This concludes my prepared statement. I appreciate the opportunity to appear before the Committee and welcome the opportunity of working with the Congress in not forgetting the mentally ill Vietnam-Era Veterans who remain in need of mental health care. We are pleased to respond to any questions that you may have.

STATEMENT OF
JOHN GRONVALL, M.D.
CHIEF MEDICAL DIRECTOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JULY 14, 1988

Mr. Chairman and Members of the Committee:

I am pleased to be here today to report on activities of the VA's Department of Medicine and Surgery concerning Post-Traumatic Stress Disorder (PTSD). The VA entered the field of PTSD study, treatment, and education as a separate and conscious focus in 1980 with the opening of the first vet centers. It was also in 1980 that PTSD was first given formulation as an officially recognized disorder by the American Psychiatric Association in its Diagnostic and Statistical Manual III. During the relatively brief period since then, the Agency has made important advancements in the assessment and treatment of this disorder. Through experiences gained from a broad range of clinical services and program initiatives, VA clinicians and scientists have achieved the status of national leadership in this field. With full acknowledgement that more remains to be accomplished, we remain committed to ongoing excellence in treating the psychological as well as the physical trauma of war.

Mr. Chairman, it is useful to summarize briefly our current knowledge about Post-Traumatic Stress Disorder. Almost all persons who experience traumatically stressful events, which include for example war, personal criminal assaults, civilian man-made and natural disasters, and torture, manifest symptoms of a post-traumatic stress reaction. These occur as individuals attempt to master and integrate the unusual impact of traumatic stress. In some persons, these symptoms run a course of several months and then recede. However, in other individuals post-traumatic symptoms persist, in which cases the diagnosis of Post-Traumatic Stress Disorder, or PTSD, is applicable.

PTSD is a generic condition, observed in survivors of the full range of traumatic stress experiences. However, certain features of the disorder are more prominent in survivors of certain types of trauma than in others. For example, survivor guilt may be prominent in war veterans or survivors of civilian disasters, but not in those who are subjected alone to criminal assaults.

In war veterans, against the background of the near-universality of some post-traumatic symptoms in those who have experienced traumatic stress, the fact that PTSD persists as a condition in only some survivors has occasioned considerable interest. Clinical experience and research in the recent past indicate that the reasons for this persistence are multiple, and include variations in the qualities and quantity of the traumas, the immediate social supports of the traumatic situation, the longer term community and social response to the veteran, individual personality factors, and whether or not early therapeutic intervention is provided. In addition, very recent research suggests the possibility that some persons with PTSD may have a physiological impairment, which may either pre-date traumas or be caused by them.

PTSD has a wide variety of degrees of severity and clinical course, ranging from relatively brief course to a chronic and recurrent course, and from mild to very severe. In addition, PTSD may be complicated by other psychiatric disorders, including substance abuse, as well as by persisting maladjustments and interference with functioning in crucial areas of living, such as employment, educational career, and family life. It is useful to regard PTSD as a spectrum disorder, with some individuals meeting the full diagnostic criteria for the disorder, and others, while not meeting the full diagnostic criteria, who show evidence of sub-clinical PTSD through impairment of functioning on the job or in the family. The natural course of the disorder in many individuals shows a pattern of waxing and waning of symptoms, with symptom-free intervals alternating with periods of manifest symptoms.

The treatment needs of veterans with PTSD reflect this variety of degrees of severity and clinical courses. At the heart of the treatment process is the need for most of those who suffer from PTSD to bring to light in psychotherapy or counseling, the details of memories of traumatic experiences, and the accompanying intense emotions. Because PTSD often involves a break in the veteran's normal social connections to family and community, the treatment process requires considerably more trust and rapport between the veteran and service provider than the usual therapeutic relationship. The treatment process also requires a period of repeated exploration and working through of the meaning of the traumatic experiences in the individual's life. Careful diagnostic assessment is required, with particular attention to the longitudinal life history and course of the disorder, and assistance for concomitant substance abuse. Some cases of PTSD also require psychiatric medication, carefully tailored to the specific needs of the individual and based on accumulated knowledge about the medications useful for PTSD. To a significant degree, the personal qualities and training and experience of the service provider are germane to the provision of successful treatment.

Group psychotherapy or counseling is particularly effective for some veterans with PTSD, in that it furnishes the veteran with supportive comparisons and therapeutic help from peers. Particularly in chronic or recurrent cases, where there has been a long term history of the disorder, family counseling may be necessary to enable the veteran's spouse and others to understand the veteran's PTSD and the recovery process.

Clarification of standards for diagnosis by the American Psychiatric Association in its Diagnostic and Statistical Manual in 1980, and as revised in 1987, has greatly assisted the clinical assessment of this condition. However, effective clinical assessment and diagnosis also requires the collection of subjective and often quite subtle personal information from the veteran, and skilled assessment of that data with reference to diagnostic standards.

In the Veterans Administration and in the private sector, not all professionals are able to provide ongoing treatment for PTSD, because of the high degree of specialization required and also because of the often painful character of traumatic experiences which must usually be reviewed for an adequate therapeutic effect. Therefore, it is important to emphasize that our objective in staff hiring and training is that all relevant staff should be skilled at performing a thorough assessment and evaluation of veterans with PTSD, but not that all staff should be expert providers of ongoing treatment of PTSD. On the other hand, because of the centrality of services for PTSD to the mission of the Agency, our objective is to field an adequate number of staff with skills in providing treatment.

The VA provides treatment to veterans suffering from PTSD through several DM&S program initiatives. Established in response to authorizing legislation in 1979, the Agency's nationwide network of community-based Vet Centers initially defined post-war readjustment counseling through provision of an innovative mix of services. With an average staff size of four persons, Vet Center teams provide counseling and psychotherapy for PTSD, employment and educational counseling, community networking and education, and referral for other needed psychiatric and social services. Vet Center service providers include an interdisciplinary mix of professional and para-professional counselors who, through their accumulated experience over the years, have significantly expanded the Agency's role in providing counseling and psychotherapy services for Post-Traumatic Stress Disorder. Vet Center assistance for PTSD includes group, individual and family counseling and psychotherapy. The VA currently operates 188 Vet Centers nationwide with another two being established in West Virginia and four in Hawaii.

The success of the Vet Centers in treating PTSD is due in part to the fact that approximately 60% of service providers systemwide are themselves Vietnam Theatre veterans and another 25% are Vietnam era veterans. The personal experience of a large number of staff with duty in a war zone, combined with professional skills which have been refined since 1980, has furnished the Agency with a nucleus for systemwide improvements of services in this area. The convenient location, small size, and non-institutional character of Vet Centers has greatly assisted our upgrading of services in this area. Further, the non-medical milieu of Vet Centers helps to create a post-war recovery environment which speeds the rehabilitation for readjustment problems.

A principal function of Vet Centers is outreach. Through activities in the community, staff locate, inform, and engage individual veterans in order to provide readjustment counseling at the Vet Center, and also to assist veterans in obtaining services from the medical facilities and from non-VA resources. Outreach includes working closely with community leaders and agencies in order to enhance awareness of VA services and facilitate links between the VA and community agencies. Through such efforts, staff became familiar with the resources of the community, and the particular features of the community in which veterans are living. The mobility of staff outreach functions outside the Vet Center contributes greatly to easing access to the VA system for the target population of veterans.

From FY 1980 through of FY 1987, Vet Centers had seen approximately 480,000 veterans and approximately 150,000 family members or significant others, with a total of approximately 3.26 million visits. Approximately one-third of veterans (158,000) seen have been for PTSD, diagnosable according to present standards. The workload at Vet Centers during FY 1988 is at about the same level as for 1986 and 1987, and there are no indicators of fall-off in demand for and utilization of services.

Some veterans with PTSD applying to Vet Centers require treatment at VA medical facilities for other psychiatric disorders, or require medication for PTSD. Therefore, a number of cases are referred from Vet Centers to medical facilities. In addition, Vet Centers serve as an after care resource for veterans discharged following inpatient PTSD treatment at medical facilities. In this context, the collaborative activities between medical facilities and Vet Centers have developed extensively with a doubling of referrals in both directions during the past three years. Another key area of collaboration is mutual participation by Vet Center and medical facility staff in clinical activities such as assessment and treatment conferences at both locations. We have also seen enhanced liaison between Vet Centers and VA Medical Centers with the development in the last year of PTSD Treatment Teams at a number of VA Medical Centers. One of their roles has been to provide consultation to Vet Centers and to enhance coordinated care for veterans between the medical center and the Vet Center.

For veterans who live at a distance from Vet Centers or VA medical facilities, the Readjustment Counseling Service operates a fee-contracts program for counseling or psychotherapy for PTSD. Private sector providers may obtain contract provider status through a competitive process which includes evaluation of professional qualifications and experience specifically with PTSD, and veterans may be referred for treatment by the private provider, with reimbursement from the VA.

During the past few years, Vet Center client activity records indicate a moderate increase in cases showing recurrence of PTSD symptoms in veterans seen a few years previously for assistance either at the Vet Center or another VA element. Most of these are cases where there had been no diagnosis or treatment for PTSD prior to 1980. This chronicity or recurrence phenomenon (also currently seen at VA Mental Hygiene Clinics) has been noted by the Chief Medical Director's Special Committee on PTSD. In addition to reflecting an inherent tendency to chronicity in some cases of PTSD, this probably reflects also the fact that little assistance for PTSD in Vietnam veterans was available from either VA or non-VA sources prior to 1980.

Finally, as noted in the Administrator's Report to Congress on the Vet Centers (April 1987) this system is providing effective crisis intervention for veterans whose PTSD has led to unusual agitation and desperate behavior. In a number of such cases, lives have been saved through calm and effective intervention. More routinely, staff succeed in establishing report with chronically angry and alienated veterans, resulting in their obtaining needed help and eventual reintegration into community and family life.

While the Vet Centers were the first VA programs to address PTSD in an organized way, the VA Medical Centers have increasingly developed expertise and programming in the treatment of PTSD as well. While there are specialized PTSD treatment programs in the VA Medical Centers as will be discussed below, currently most of the medical centers' treatment of PTSD takes place on the general psychiatry inpatient and outpatient units. Various levels of care are provided on the VAMC units from inpatient evaluation and treatment to partial hospitalization programs (in Day Hospitals and Day Treatment Centers) to outpatient Mental Hygiene Clinics providing individual and group therapy. Mental Health consultation liaison services also identify and recommend management and follow-up for PTSD. Many veterans suffering from PTSD have an associated diagnosis of alcohol or other substance abuse, and may receive treatment in our alcohol or substance abuse units.

On these general psychiatry units, staff particularly interested in PTSD may establish treatment "tracks" or mini-programs. As already noted above, they involve close interaction with Vet Centers. A study is in progress to determine how many veterans with PTSD are seen in general psychiatry programs and how many are seen in specialized units.

There are several kinds of VA programs that provide specialized PTSD treatment exclusively. Specialized Inpatient PTSD Units were first established with VA Central Office support at 13 locations in 1984. Since then other Specialized Inpatient Units have been established in three other VA Medical Centers, Buffalo, NY; Little Rock, AR, and Togus, ME. Also, the VAMC's at Albuquerque, NM and Minneapolis, MN have established outpatient PTSD programs.

The role of the Specialized Inpatient PTSD Units is to provide diagnostic, evaluation and treatment services to veterans whose PTSD is so severe or complicated that they cannot be adequately cared for by other VA inpatient or outpatient services. The innovative nature of the Specialized Inpatient PTSD Units has resulted in some variation in programmatic approaches depending upon the perceived needs of the patient populations and the unique skills and expertise of the staffs. All the units, however, address the issues of combat trauma, symptom resolution and re-entry into society of the patient with from PTSD. Many Specialized Inpatient Units have served as faculty for VA educational programs on PTSD. Some of the Specialized Units have developed clinical research projects on PTSD.

In FY 1987, the VA launched a new initiative authorizing PTSD Treatment Teams for 15 VA Medical Centers without Specialized Inpatient Units. The Teams represented a different level of care than the Specialized Inpatient Units. Each PTSD Treatment Team consists of at least one psychiatrist and three other qualified clinicians. The Team's role is to provide care for PTSD through inpatient consultation and outpatient work; to coordinate care with local Vet Centers; and to promote education on PTSD within and outside of the Medical Center.

There is currently some form of special PTSD treatment program in 20 of the VA's 27 Medical Districts. In addition, there are a number of PTSD programs in the field that are in the beginning or developmental stage. A Mental Health and Behavioral Sciences Service survey, currently in progress, will identify the total number of such programs. The need and demand for PTSD treatment services in VA Medical Centers has not leveled off and will continue. Accordingly, VA staff is continuing to plan program development to meet this need.

In FY 1984, 5,070 individual Vietnam veterans were discharged with a diagnosis of PTSD, in the VA system, nationwide, while in FY 1985, 7,048 Vietnam veterans were discharged with a diagnosis of PTSD. A separate survey of the 198787 Patient Treatment File showed 15,038 patients of all eras discharged with a diagnosis of PTSD from all bed sections of the VA nationwide. This figure includes 11,643 discharges with from psychiatry services and an additional 1,376 discharges from alcohol and other substance abuse programs. The implication of these figures is that more Vietnam veterans with PTSD are using the VAMC for care and/or that more PTSD is being diagnosed.

An outpatient survey (for the period September 8, 1986 through October 3, 1986), found that 19.3% of all Vietnam Era veterans in VAMC outpatient mental health programs were diagnosed as having PTSD, making PTSD the sixth most frequent diagnosis seen at these sites. Almost one-third (30.5%) of all PTSD treated in VAMC outpatient programs is found in veterans outside the Vietnam era (21.7% from WWII, 5.1% Korean Conflict). Of patients who received psychiatric interviews in the VA's Homeless Chronically Mentally Ill Veterans Demonstration Project, 9.4% were diagnosed as having PTSD.

The Chief Medical Director's Special Committee on PTSD established in 1984, is a multi-disciplinary group of clinician experts on PTSD, with representation from VA Medical Centers and Vet Centers, which meets several times a year. The four Annual Reports submitted thus far by the Special Committee to the VA and to Congress, document their study of the VA's efforts with regard to the diagnosis, treatment, research, educational and fiscal aspects of PTSD. A significant database on treatment activities was presented in the Committee's Third Annual Report (1987). The Special Committee deserves praise for the outstanding job it has done in assisting the VA to develop and document its progress in the treatment of PTSD.

The CMD's Special Committee has made a total of ninety-seven recommendations in its first three Annual Reports, as well as forty-two recommendations in the Second Annual Report that are guidelines for Specialized Inpatient Units. A number of the recommendations have been carried over from one report to the next. Some of the recommendations that were not implemented in an earlier report were resolved by the time subsequent reports were written. For the Third Annual Report, thirty-seven of the thirty-nine recommendations received CMD concurrence. The two exceptions were the suggestion that for patients unequivocally diagnosed by clinical interview and corroborated by standardized psychological and psychophysiological tests, that the standards of evidence for establishing a stressor be eased; and, the expansion of eligibility for services at Vet Centers to include combat veterans from all wars. The Fourth Annual Report differs from its predecessors in that it describes ongoing activities of the Committee rather than providing specific recommendations. The Agency believes that these activities will result in improvements in the VA's ability to treat PTSD.

Concern has been expressed by the Special Committee over the effects of the VA's Resource Allocation Methodology (RAM) on the treatment of PTSD, especially on the Specialized Inpatient PTSD Units. The RAM for inpatients is based upon the Diagnosis Related Group (DRG) system, which is designed to control hospital costs and promote efficiency by providing a fixed amount of resources for the care of a patient based upon that patient's diagnosis. Length of stay is a marker for earnings, with a certain amount being paid for patient care between a low and high "trimpoint" (2 - 45 days for DRG 427 which includes PTSD). After 45 days, an "outline" rate is paid.

Since most Specialized Inpatient PTSD Units have treatment programs greater than 45 days (the average length of stay is between 9 and 11 weeks), it is readily apparent that these programs may not be "moneymakers" under the RAM. Questions have also been raised about the amount of resources allocated under DRG 427 even for the 45-day period.

The issue, however, is less what the RAM pays for PTSD but how the treatment of PTSD patients is effected by it. Although there may be a fiscal pressure for shorter length of stay for a given program, resource allocation decisions for a bed service and for a whole Medical Center are based on the overall case-mix, the overall earnings and losses for that service or Medical Center. Hence, a PTSD Unit in a Psychiatry Service may "lose" under the RAM but that service could still be an overall fiscal "winner."

The Specialized Inpatient Units have adapted in a variety of ways. One program has developed six-week treatment phases separated by periods outside of the hospital to practice some of the skills learned in treatment. Another site has managed to be a consistent RAM "winner" with an 85-day program. Still another program has organized itself as a 28-day inpatient program with outpatient support. To date we have no formal evaluation of outcome comparing the clinical effectiveness of these programs and so it is difficult, if not impossible, to speak about the effect of the RAM or of shortened lengths of inpatient stay on PTSD patients. It should be noted that within the VA there is currently under review, a proposed revision of the DRG's for Mental Health which would include a specific DRG for patients requiring care on a Specialized Inpatient PTSD Unit.

Much of the treatment for PTSD is empirical in nature, that is, clinicians have applied to the treatment of PTSD symptoms, approaches that have been found to be useful in treating these symptoms when they are manifested in other disorders. This empirical approach of using what seems to work best is common not only in the treatment of PTSD, but in other areas of medicine as well. The various treatment modalities can be applied in almost all of the treatment settings described above, depending upon the needs of the patients and the particular skills and expertise of the treatment staff.

How effective are the treatment modalities discussed below? Realize that for both psychotherapeutic and pharmacological approaches, controlled studies and overall treatment efficacy (outcome) studies are just beginning to be developed. Again, this says nothing unique about PTSD, rather, we are just entering the era of scientifically valid treatment efficacy and outcome studies. A massive NIMH study on the efficacy of various treatment modalities for depressive disorders was only completed in the past two years. There remain questions in many areas of medicine and surgery about the relative merits of one form of treatment over another. Until controlled outcome studies are completed, one can only say that a treatment is effective if it serves to decrease symptoms and improve patient functioning.

In the treatment of PTSD, behavioral, cognitive, existential and psychodynamic psychotherapies all have a place, as do various pharmacological approaches. Alone or in combination, these methods can reduce the disruptive symptomatology of PTSD and facilitate the reintegration of the veteran into the community. The goal of psychotherapy for PTSD is to improve the patient's ability to cope with stress, to enhance their cognitive and emotional processing of the trauma and to improve their social and occupational functioning. Intrusive symptoms such as flashbacks and nightmares may require treatment methods which lower heightened physiological arousal, such as relaxation training, desensitization and cognitive restructuring. Avoidant behaviors which tend to isolate the patient may be corrected with assertiveness and communications skills training. Veterans can learn through these techniques that confronting feelings and dealing with others need not have catastrophic consequences.

Group psychotherapy may be particularly useful for patients with PTSD because of the sense of shared experience and support that it provides. Among the group approaches that have been employed are: educational group (dealing with the history of the Vietnam War and the nature of PTSD); combat/trauma group (to aid in the expression of feelings and clarification of roles), anger management groups; and community reorientation groups (various types: these promote reintegration with the family and the community at large including some that focus on work-related behavior). Family therapy or vocational counseling may be required to meet the needs of specific veterans. Often the patient moves through a sequence of therapy experiences, first learning about the nature and psychobiological basis for PTSD, then working to overcome or control pathological symptoms and finally being helped to reintegrate into the community.

Pychotherapy has been, and remains, the basic treatment for PTSD at this time, however, recent studies have suggested persistent biological imbalance associated with PTSD. Pharmacologic treatment of PTSD alone is not sufficient to resolve the disorder, but medications may, in a number of cases, help to control symptoms and enhance the patient´s ability to become effectively engaged in psychotherapy. A most thorough treatment of the use of medications in PTSD has recently been published in the American Journal of Psychiatry (145:3, March 1988, pp. 281-285). This paper, entitled "Toward Rational Pharmacotherapy for Post-traumatic Stress Disorder: An Interim Report," was authored by Matthew J. Friedman, M.D., Ph.D. Dr. Friedman, who has been invited to testify at today´s hearing, is Chief of Psychiatry at the White River Junction (VT) VA Medical Center and Chairman of the CMD´s Special Committee on PTSD. The article expresses the concepts of pharmacologic treatment of PTSD that have been presented in the VA´s PTSD education programs.

To summarize antidepressants have been effective in controlling a variety of PTSD symptoms including nightmares and flashbacks; success with rage and mood disorder symptoms has been reported with lithium carbonate. Benzodiazepine minor tranquilizers may be effective, especially for crises, but there must be concern about their addiction potential and other risks. Other antianxiety agents (beta-blockers, alpha-2 agonists) have been reported as effective for intrusive thoughts and explosivity. Antipsychotic medications are not indicated for PTSD except for those rare cases where there are true psychotic symptoms. In such situations the minimum effective dose should be used for as short a time as possible.

The VA's clinical experience with PTSD has shown us that the disorder can be chronic, with a potential for recurrence of symptoms in times of stress in some patients. Our planning for treatment programs takes this characteristic of the disorder into account.

On November 16-18, 1987, in response to a request from the Chief Medical Director, a team from the Special Committee, with Mental Health and Behavioral Sciences representation, made a site visit to the National Center for Stress Recovery (NCSR) located at VA Medical Center, Brecksville, OH. The purpose of this visit was to determine how well the Center for Stress Recovery had functioned as a National Center for PTSD . The National Center was established to: (a) carry out and promote research into and train clinicians in the diagnosis and treatment of PTSD; and (b) serve as a resource center and promote the exchange of information regarding all PTSD research and training activities conducted by VA and non-VA facilities.

The Special Committee concluded that the Center for Stress Recovery had been unable to meet the Congressional mandate to function as a National Center for PTSD and that it was unlikely that the CSR could be transformed into a National Center for PTSD in the foreseeable future. The Special Committee report included recommendations on the future mission, operation and organization of a National Center for PTSD.

The Special Committee's report was reviewed in VA Central Office and the decision was made to submit to the field a Request for Proposals (RFP) to create a National Center for the Study of PTSD (NCS.PTSD) that would truly meet the purposes for which it was created. Mental Health and Behavioral Sciences Service, Readjustment Counseling Service, DM&S Region 4 (which includes the Center for Stress Recovery), as well as the Special Committee all participated in this process. It is anticipated that the RFP will be released to the field this month and that a National Center for the Study of PTSD will be designated in January 1989. The RFP will require a very thorough and careful submission from the applicants and the submissions will receive a most thorough and fair review process.

We intend to retain a Specialized Inpatient PTSD Unit at VAMC Brecksville despite the probable transfer of the National Center to another facility. (The term probable is used because VAMC Brecksville will be eligible to compete for the NCS.PTSD designation).

VA Research in PTSD

Research Triangle Institute Study:

By Congressional mandate, the VA initiated in 1983 a fully-contracted out nationwide epidemiologic study on PTSD in Vietnam Veterans. The National Vietnam Veterans Readjustment Study or NVVRS is being conducted by the Research Triangle Institute of North Carolina. The investigators have completed field interviews of 3032 subjects, including Vietnam theatre, and Vietnam era veteran samples, plus a civilian comparison sample. This study is the most comprehensive study to date on PTSD and other post-war readjustment problems in Vietnam veterans, and as well is the first psychiatric epidemiologic study on PTSD and several other psychiatric conditions ever conducted in the United States on national samples. Much of the credit for the quality of the final results of this study in terms of the depth of understanding of the nature of PTSD in Vietnam veterans, must go to Dr. Terry Keane, who for the past 1-1/2 years has been the Chairman of the VA's Technical Advisory Group for this project. The results of this study will be reported to the VA and to the Congress later this year. I wish to take special note of a finding in the Preliminary Report from this Study, submitted earlier this year to the Committee, which suggests that a relatively small percentage of Vietnam veterans with PTSD have thus far obtained services from any VA component. A significant obstacle to client accessibility for PTSD treatment is overcoming the veterans' denial of and resistance to confronting the extremely painful memories related to traumatic war experiences. Many veterans do not present for services until many years after the war when other secondary complications such as substance abuse have further impeded their functioning. This fact underscores the importance for the VA to continue the availability for PTSD treatment with particular emphasis on outreach activities by Vet Centers and PTSD treatment teams.

In April 1988, the Special Committee submitted a report to the CMD on VA research on PTSD in 1987. The report, based primarily on data provided by VA Central Office on April 8, 1988, showed 67 VA approved research projects on PTSD that were approved either as an initial project or as a continuation project in 1987. The funding for these projects from VA sources, $832,121.00, represents 5.5% of the total VA funding for Mental Health research. This represents a 29% increase in all projects, a 50% increase in VACO funded projects and an 11% increase in locally funded projects over 1986 levels.

The Special Committee has had discussions on the usefulness of outcome studies of PTSD treatment and some of the problems associated with such studies. We hope that a National Center for the Study of PTSD will greatly enhance this and other PTSD research including treatment outcome, care delivery and basic biological studies.

PTSD Education

In an effort to get PTSD education off to a strong start, there was a national focus on PTSD education in the VA in fiscal years 1985, 1986 and 1987. During this time, a number of educational programs were carried out with the assistance of the VA's system of Regional Medical Education Centers (RMEC's). A PTSD Education Committee was formed with membership from the Special Committee, Mental Health and Behavioral Sciences Service, the Mid-Atlantic RMEC located at VAMC Brecksville and the Center for Stress Recovery. The role of this Committee has been to plan and coordinate PTSD education in the VA health care system.

With the decline of the National Center for Stress Recovery, the Education Committee is continuing to plan and carry out PTSD education. In FY 1987, for example, nine educational programs were carried out under the direction of the Education Committee: two being national in scope, two being regional and the rest carried out at the medical district level. In FY 1987, the VA Continuing Education Field Units carried out 42 PTSD programs, training 2773 participants. This is the mechanism by which the Special Committee's educational recommendations are being carried out. Special care has been taken to present integrated presentations for VA Medical Center and Vet Center staffs. A number of presentations have included personnel from the Department of Veterans Benefits (DVB) as well.

For FY 1988, three major educational projects are being planned, with RMEC support. One is a series of videotaped teleconferences to be carried out in every VA Region, covering the fundamentals of identification, diagnosis and treatment of PTSD. It is designed to inform non-mental health staff (potential referral sources) as well as mental health clinicians. The second project is a training program for PTSD Treatment Team staff that will cover clinical issues, networking, reporting of workload and outcome evaluation. The third project, being carried out in cooperation with DVB, is the development of a training module for physicians doing Compensation and Pension exams for PTSD. We anticipate having this program in the field early in FY 1989. In addition to these educational activities, there has also been an ongoing program of staff education provided by Readjustment Counseling Service, with participation by medical facility staff members, which features PTSD as a main focus, along with other aspects of readjustment counseling services. It is anticipated that future educational programs on PTSD will focus on "co-diagnoses," especially patients with both PTSD and alcohol or other substance abuse and PTSD in special groups such as females, Blacks and the physically disabled. In the future, PTSD education will continue and evolve as new staff join the VA, as new treatment approaches are developed and as PTSD patients age.

Compensation Issues

The Special Committee has made several recommendations concerning the adjudication of claims for service-connected compensation for PTSD. With but a few exceptions, these have been adopted by the Department of Veterans Benefits (DVB). Perhaps the most significant accomplishment arising from a Committee recommendation was the creation of a computer data base which monitors the number of PTSD claims adjudicated by each regional office and provides recurring reports on the rates of approval or disapproval of claims and (if service connection has been established) the disability evaluation (level) assigned. This data base shows that since June 1, 1985, 29, 171 claims for PTSD have been adjudicated. The vast majority of these claims were filed by Vietnam Era veterans. Service connection was granted or an increased disability rating was assigned in 15,957 or 54.7 percent of these cases. The average level of disability was 10 to 30 percent. (It should be noted that DVB has been granting service connection for PTSD claims since 1980, before the data base was created. Our payment records indicate that over 22,000 veterans receive disability compensation for PTSD.)

The Special Committee has expressed concern about the disparity between regional offices with regard to the rates of approval for PTSD claims and the disability evaluation assigned. DVB objects to the assumption that all regional offices must fall into "normal" ranges and that failure to do so is solely the result of "bad" adjudication. The demographic and cultural mores of the veteran population served by a regional office affect the number, type and severity of PTSD claims received. The presence of an active Vet Center and/or the existence of extensive publicity concerning PTSD also affect a regional office's statistics. DVB monitors its PTSD reports carefully and investigates situations in which there appears to be an extreme variance in the disposition of PTSD claims. However, it is not VA policy to force regional offices to meet artificial "ranges" for approval rates or disability evaluations. VA policy continues to be that each veteran and each claim is different and each claim must be evaluated on it's individual merits.

Briefly stated, there are two basic requirements which must be met before a regional office rating board can grant service connection for PTSD. First there must be a thorough psychological examination which gives not only a diagnosis of PTSD but also discusses in detail the veteran's past and present symptoms and gives a history of the stressful event or events during military service which are thought to have caused the PTSD. Secondly, there must be documentation from military records which supports the reasonable conclusion that the alleged event did occur.

This second requirement represents the one area of disagreement between DVB and the Special Committee. The Special Committee believes that, in lieu of searching military records for evidence which supports the reported stressful event(s), DVB should accept the diagnosis presented by the clinician, provided that the clinical interview has been corroborated by data from appropriate standardized assessment instruments. DVB recognizes that for diagnostic and treatment purposes a clinician can accept a patient's self-reported history and exercise professional judgment in evaluating that history. The establishment of service connection, however, is a legal rather than a medical decision. The law requires that before monetary payments are made, there must be evidence of record, beyond the veteran's own statements or the clinician's findings, sufficient to permit the rating board to reasonably conclude that the stressful event occurred a claimed.

As noted above, considerable progress has been made in implementing the Special Committee's recommendations pertaining to PTSD educational programs and better communications between DVB and DM&S. This improved cooperation will result in more efficient and more accurate adjudication of PTSD claims.

VA Leadership Regarding PTSD:

The program activities highlighted in this statement indicate major accomplishments of the VA in services to veterans with PTSD, particularly since 1980. In addition, I wish to take special note of the professional leadership which VA staff are providing in this area, which is proving to be of benefit not only to veterans, but which is extending beyond the VA to the field of traumatic stress in general. In recent years, numerous professional papers and books have emerged from VA clinicians and researchers (both funded and non-funded). To cite only a few examples of this leadership: Analysis of DM&S diagnostic standards by Elizabeth Brett, Ph.D., and Robert Ostroff, M.D., formerly of the West Haven, CT VAMC, led to useful revisions of the diagnostic standards by the American Psychiatric Association. The APA Committee on PTSD for the 1987 edition of the Diagnostic and Statistical Manual utilized the services of eight VA professionals, including the Director of the Readjustment Counseling Service, Dr. Arthur S. Blank, Jr. The Chairman of the Chief Medical Director's Special Committee on PTSD, Dr. Mathew Friedman, Chief of Psychiatry at the White River Junction, VT VA Medical Center, provided a lead article this year in the American Journal of Psychiatry, on the state of the art of pharmacologic treatment of PTSD. Dr. Terrence Keane, Chief of Psychology at the Boston, MA VA Medical Center, who provides the VA's oversight of the National Vietnam Veterans Readjustment Study, is a leader in the field of measurement of PTSD. Mr. Chairman, this completes my prepared statement and I will be pleased to respond to questions.

Department of Veterans Benefits
Veterans Administration
Washington, DC 20420

DVB Circular 21-86-10

September 4, 1986

POST TRAUMATIC STRESS DISORDER

1. The purpose of this circular is to provide guidance in rating claims for PTSD (post traumatic stress disorder).

2. The issue of service connection is the sole responsibility of the rating board at the local level. In making that decision, it is important that the examining psychiatrist present a clear diagnosis showing a detailed history of the stressful events which are thought to have caused the condition and a full description of past and present symptoms. Because of the complexity of PTSD, the application of careful clinical judgment is necessary to identify and describe the relationship between past events and current symptoms. Service connection for PTSD will not be established on the basis of a diagnosis of PTSD unsupported by the above history and description or where the examination and supporting material fail to indicate a link between current symptoms and an inservice stressful event(s).

3. In determining whether PTSD is service connected, rating boards will consider the following factors:

a. The inservice traumatic stressor(s) must be adequately described by the examining VA psychiatrist. In addition, the examining psychiatrist should comment on the presence or absence of other traumatic events and their relevance to current symptoms. Relevant specific information concerning what happened must be described along with as much detailed information as the veteran can provide to the examiner as to the location in time (year, month, day), geographical location (corps, province, town, or other landmark feature such as a river or mountain), and the names of others who may have been involved in the incident. Examinations that are inadequate should be returned to the VAMC for reexamination.

b. Any evidence available from the service department verifying that the veteran served in the area in which the stressful event is alleged to have occurred (as described in subparagraph a above) and any evidence supporting the description of the event should be made part of the record. When the claimed stressor is related to combat, evidence of receipt of the Purple Heart, Combat Infantryman Badge, Bronze Star, and other similar citations are considered supportive evidence indicating possible involvement in a stressful episode. Other supportive evidence includes, but is not limited to, plane crash, ship sinking, explosion, duty on a burn ward or in a graves registration unit, and similar assignments. POW status is conclusive evidence of an inservice stressor.

4. When a claim for PTSD is received the following development will be undertaken:

a. Request all service medical records if not previously obtained.

b. The remarks section of VA Form 21-2507, Request for Physical Examination, will state "Claims folder to be made available to examiner upon request."

c. When the veteran indicates pertinent treatment in a VA facility or elsewhere, request for hospital report(s) and clinical records will be made. If Vet Center participation is indicated, the Vet Center records will also be requested.

d. In cases where records available to the rating board do not provide objective or supportive evidence of the alleged inservice traumatic stressor, it will be necessary to develop such evidence. While inservice traumatic stressors do not have to be documented to an absolute certainty, the supportive evidence of record must be sufficient to permit a rating board to reasonably conclude that the stressful event occurred as alleged. When necessary, development of such evidence will be accomplished as follows:

(1) The veteran will be requested to furnish specific details of the inservice stressful incident(s) such as date(s), place(s), unit of assignment at the time of the event(s), description of the event(s), medal(s) or citation(s) received as a result of the event(s), and if appropriate, name(s) and other identifying information concerning any other individuals involved in the event(s). The veteran should also be informed that the information is necessary to obtain supportive evidence of the stressful event(s) and that failure to respond may make it difficult or impossible to obtain such evidence.

(2) At the same time, the service department should be requested to furnish copies of appropriate pages from the veteran's personnel file showing unit assignments, dates of assignments, participation in combat operations, wounds received in action, awards and decorations, and official travel outside of the Continental United States.

(3) When the requested information from both the veteran and the service department is received, a letter should be sent to the U.S. Army and Joint Services Environmental Support Group, DAAG-ESG, 1730 K. Street, N.W., Room 210, Washington, DC 20006, requesting supporting evidence. Copies of information received from the veteran and the service department are to be enclosed with such requests. A VA examination which adequately describes the alleged stressors may be paraphrased as to the alleged stressors and enclosed to the Environmental Support Group if veteran does not respond to the request for details of the stressors.

5. In making a decision, the rating board will exercise fair, impartial, and reasonable judgment in determining whether a specific case of PTSD is service connected. Some relevant considerations are discussed below:

a. PTSD can be caused by events which occur before, during or after service. The relationship between stressors during military service and current problems/symptoms will govern the question of service connection. Symptoms must have a clear relationship to the military stressor as described in the medical reports.

b. PTSD can occur hours, months, or years after a military stressor. Despite this long latent period, service-connected PTSD may be recognizable by a relevant association between the stressor and the current presentation of symptoms. This association between stressor and symptoms must be specifically addressed in the VA examination report and to a practical extent supported by documentation as expressed in paragraphs 3a and b, and when applicable 4d.

6. Although it is expected that most PTSD claims will be resolved at the local level, Central Office opinion or guidance may be requested on complex cases. Cases or inquiries should be directed to the Chief, Regulations Staff (211B). The telephone number is FTS 389-3005.

7. RESCISSION: DVB Circular 21-82-7 and change 1.

R. J. VOGEL
Chief Benefits Director

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Department of Veterans Benefits
Veterans Administration
Washington, DC 20420

DVB Circular 21-86-10
Change 1
November 13, 1986

POST TRAUMATIC STRESS DISORDER

1. PURPOSE: Paragraph 3b is revised to further clarify other supportive evidence of stressful events that may be considered in PTSD claims.

2. DVB Circular 21-86-10 is changed as follows:

Page 1, paragraph 3b, line 10: After "explosion," add "rape or assault,".

R Vogel

R. J. VOGEL
Chief Benefits Director

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SEP - 8 1987

Director of C&P Service (214A) 344/21
Veterans Administration Central Office
810 Vermont Ave. N.W.
Washington, DC 20420

SUBJ: Review of Post Traumatic Stress Disorder Cases

1. Following receipt of the semi-annual staff analysis of Adjudication Division operations April 7, 1987 and a listing of PTSD cases found in SIRS for the Los Angeles Regional Office dated April 24, 1987, a review of a sample of PTSD cases was conducted.

Cases reviewed:	59
Claims granted:	21
Claims denied:	38
Percent of claims granted:	35.6

2. A careful review was made of those cases wherein service connection for PTSD was denied. The denials fell into 3 groups:

		Number	Percent
a(1)	No diagnosis of PTSD after an adequate examination:	18	47
(2)	Veteran failed to report for VAE:	3	7.9
b.	Denied without examination because there was no service related stressor or alleged stressor was not supported by the evidence of record:	7	18.4
c(1)	Probable or possible (not definite) diagnosis of PTSD - No testing conducted on VAE:	3	7.9
(2)	PTSD diagnosed but stressor was not supported by the evidence of record:	3	7.9
(3)	Diagnosis not supported by the findings:	4	10.5

3. In the majority of denials, 55.3 percent, the actions were clearly proper. The veteran either failed to report for the examination or did not receive a diagnosis of PTSD. In an additional 7 cases, there was no stressor alleged, no service related stressor or the alleged stressor (usually "combat") was not

supported by the evidence of record (i.e., no RVN or KC service). (In one case, the veteran had peacetime service in the Coast Guard; his stressor was shown as "child abuse".) Therefore, in 28 of 38 denials (73.7 percent) there was no indication that the decisions were inappropriate. Additionally, our review failed to indicate any SIRS related or diagnostic code problems as mentioned in paragraph 3 of your April 24, 1987 letter.

4. The remaining 10 cases had examinations which were deficient outright, or were deficient when compared to the evidence of record. These cases had ambiguous diagnoses (probable or possible) or had PTSD diagnosed but that diagnosis was not supported by either the evidence of record (a stressor was not evident) or by the examination findings (a stressor was not detailed on the examination). The examinations in most of these cases should have been returned to the medical center as inadequate. In three of the cases, additional development with the veteran should have been undertaken to verify the alleged stressor.

5. Training classes dealing with the type of cases outlined in paragraph 4, above have been scheduled for the Rating Boards. Denials of service connection for PTSD will be reviewed by Section Chiefs commencing August 17, 1987. We will do a follow-up review in 6 months to assure that all procedures associated with PTSD cases are being followed.

LOIS HIGH
Director

21/00/238 GTW:LH:cae:1224B

PT-D

VETERANS ADMINISTRATION REGIONAL OFFICE
[illegible] N. CENTRAL AVENUE
PHOENIX, ARIZONA 85012

August 14, 1987

345/21

Field Operations Staff (214A)
Veterans Administration Central Office
810 Vermont Avenue NW
Washington DC 20420

SUBJ: Your request of July 1, 1987

1. Thirty cases were randomly selected and reviewed from the list of post traumatic stress disorder cases you furnished.

2. The following categories of verified primary stressors were found to exist upon completion of the review:

    a. POW: 7
    b. GSW/SFW: 6
    c. incidents meeting criteria of DVB circular 21-86-10 paragraph 3b: 14

3. In the remaining three cases the following applies:

    a. Two cases VA examiners added PTSD to preexisting anxiety reaction or depressive neurosis. No change in evaluation occurred.

    b. One case BVA granted SC. Regional Office could not verify the alleged stressors.

4. This completes our reply to your prior request.

DAVID M. WALLS
Director

August 1987

PROVIDENCE, RI

POSTTRAUMATIC STRESS
DISORDER REVIEW

1. From the list of 156 cases, 18 were randomly selected for review which was conducted by a former Rating Board member with more than 15 years of prior rating experience. There were four denials. It was determined that the disallowances were correct.

2. Of the 14 that were granted, one was by way of an advisory opinion from C. O. Eight of these cases were decided prior to June 1, 1985 and one is still in a denial status. In some instances, the stressors were not described with as much detail as one might wish. However, there was solid corroboration in each case by way of combat wounds and medals attesting to combat experience. In several instances, the 201 file verified combat experience. In only one case it could be argued that the stressors were questionable and the reasonable doubt was resolved in favor of the veteran. There were two cases in the sample where a remand by the BVA resulted in a final grant of PTSD.

3. A comparison of the New England States experience is interesting.

R.O.	Percent Granted	Claims Considered
301	70.5%	654
304	75.6%	172
308	66.8%	264
373	69.3%	251
402	63.3%	278
405	75.9%	29

These offices are all above the 54.2% national average.

4. It is worthwhile to note that Rhode Island is a small state and we do have a very active Viet Nam Era Veterans Readjustment Counseling Program in the metropolitan area of Providence. We feel that our review verified an objective approach to the rating of PTSD by the members of our Rating Boards.

C C July 1981

Reno, NV

EVALUATION OF POST TRAUMATIC STRESS CLAIMS

A review of Post Traumatic Stress Disorder Claims was accomplished with the following results:

6	Cases were allowed
5	Cases found no objective evidence of a stressor.
1	Case the examiner felt the diagnosis of PTSD was a reactive depression brought on by multiple sclerosis.
1	Case had stressor but no diagnosis of PTSD.
1	Case had stressor and diagnosis of possible PTSD but during hospitalization there was no evidence of claimed history of PTSD.
2	Cases of stressors, with passive aggressive personality. A diagnosis of PTSD was made but the evidence did not support the diagnosis.
1	Case had a stressor and various diagnosis including PTSD. If I had been rating the Case I would have requested an O & E. Case is now in appellate status and will be sent to BVA.
2	Cases were PTO
2	Cases were TTC for exams.
21	Total Cases

M21-1, 50.45 c (1) states that a history of a stressor as related by the Veteran is, in itself, insufficient. Yet the examinations I reviewed diagnosing Post Traumatic Stress Disorder are primarily based on a history the Veteran recites to the examiner of his reexperiencing a traumatic event or events in Viet Nam and reliving those events in his dreams causing sleep disturbance, some guilt feelings, anger, avoidance of people, loss of jobs or family or both, etc.

My Rating Board looks at the whole picture in making an evaluation for service connection for PTSD and if in their opinion they believe the evidence does not support a diagnosis of PTSD, they disallow the claim. Except for the one case I mentioned above, I believe the evaluations have been proper based on the evidence of record.

Are the Examinations adequate? In my opinion the majority of individuals claiming PTSD should be given an extended period of observation at a VA Hospital to properly diagnose this disability.

J. P. Stupfel

J. P. STUPFEL
Adjudication officer
Reno, NV

PTSD

In a 20% review, the following PTSD Claims were reviewed on January 21, 1988.

- Denied

1. The Veteran saw some combat which would indicate a Stressor exists.
2. The Veteran has a passive aggressive personality disorder with some PTSD symptoms. The symptoms being the history expressed by the Veteran to the examiner.

- Denied

1. The DD214 shows a Combat Infantry Badge which indicates a probable Stressor.
2. Primary problem is Schizophrenic reaction. Schizopaffective type claimed now as PTSD.

- Denied

1. Combat related Stressor.
2. Schizoid pattern with moderate depression.

- Denied

1. Purple Heart - Stressor.
2. Character disorder with history of alcoholism.

- Allowed

1. Combat related Stressor.
2. PTSD diagnosed.

Denied

1. Personnel records show Veteran was in a Combat Engineer Company. Doubtful Stressor. He failed to respond to request for names, dates, and places of Combat.
2. A diagnosis of PTSD is superimposed on a personality disorder associated with alcohol abuse.

ANALYSIS

I do not think we could expect any better examinations unless the Veterans were placed in a hospital for observation for an extended period. In most of the PTSD cases I have reviewed in the past, any mention of a PTSD diagnosis appears to be superimposed on a personality disorder associated with alcohol and/or drug abuse. Ratings in this office are based on the individual merits of each case and any attempt to compare the number of Claims allowed or disallowed by this office to a National Average when dealing with so few cases has little purpose since I do not have access to claims from other offices. Perhaps our variation from the National Average is because "we exercise caution to assure that situational disturbances containing adjustment reaction to adult life and the reactions of those without neurosis who have "dropped out" and have become alienated are not built into a diagnosis of PTSD." (M21-1,50.45b-3)

Regional Office

P. O. Box 50188
Honolulu, HI 96850

Veterans Administration

Tomasik

JUN 22 1987

In Reply Refer To:
359/21

Deputy Chief Benefits Director
for Field Operations (214A)
Department of Veterans Benefits
VA Central Office
810 Vermont Avenue, Northwest
Washington, DC 20420

SUBJECT: Evaluation of Adjudication Division Compensation and Pension (Your letter dated April 23, 1987)

We have conducted a 10% review of the cases for which service connection was granted for Post-Traumatic Stress Disorder. Attached are our findings and an analysis of the reasons for the variation from the national average.

SAM A. TIANO
Director

Enclosures

21/00 JWH:tr

"America is #1—Thanks to our Veterans"

A review of 10% of the cases evaluated as service-connected for Post-Traumatic Stress Disorder was conducted.

In each case reviewed a recognizable life threatening episode was presented. Objective evidence of a stresser was presented in each case. This evidence included citations for combat, newspaper articles, Purple Heart Commendations, Combat Infantry Badges, et cetera. The clinical examinations were also reviewed for completeness. The essentials for a proper diagnosis of Post-Traumatic Stress Disorder were present. Medical reports cited recurrent dreams, reactions to loud noises, changes in behavioral patterns around other individuals and existence of two or more of the symptoms cited in M21-1, Paragraph 50.45. Based upon our 10% sampling the medical reports follow the Physician's Guide for Disability Evaluation Examinations for both Chapter 14 concerning mental disorders and Chapter 20 concerning Post-Traumatic Stress Disorder. These examinations provided our rating board personnel with adequate information to properly rate these cases.

There is no pattern that emerges as to the reason the Honolulu Regional Office approval rate exceeds the national average. There are, however, a number of factors that affect our station's statistic. The number of PTSD cases worked by the Honolulu Regional Office represent less than one percent of the number of cases worked nationwide. This percentage of the workload generates a distorted picture of the approval rate when compared to the national average.

The *Diagnostic and Statistical Manual of Mental Disorders* state that symptoms characteristic of PTSD are often intensified when the individual is exposed to situations or activities that resemble or symbolize the original trauma. The demographic and geographic makeup of the areas serviced by the Honolulu Regional Office is similar to the environment many individuals experienced in Southeast Asia.

J. W. Headen, Jr.
J. W. HEADEN, JR.
Adjudication Officer

21/21 JWH:tr

Veterans
Administration

White River Jct., VT

Memorandum

Date June 24, 1987

From Adjudication Officer (21)

Subj PTSD Study

To Director (00)

Pursuant to Paragraph 2f of CO's letter of 6-3-87, a 30% random sampling of the listed Post Traumatic Stress Disorder claims was obtained and reviewed. (Every third case on that list was reviewed). Of the nine cases reviewed (dating back to 1982), seven were grants and two were disallowances. One of the seven grants was accomplished by VARO Wichita.

In each of this station's grants, there is an adequately "verified" stressor as well as an adequate psychiatric examination diagnosing a Post Traumatic Stress Disorder and supporting it with the necessary findings. In each case current symptoms are affirmatively related to the stressor experience. Two of the stressors were sent to, and supported by, the Environmental Support Group. The VARO Wichita claim appears adequately documented despite no formal 2507 examination. In neither of the two disallowances reviewed is there a diagnosis of a Post Traumatic Stress Disorder or symptoms suggesting such a diagnosis. A 2507 examination was accomplished in one disallowed claim and one was based on a VA Hospital summary. Copies of the Ratings and Exam reports are attached.

It is difficult to say why our grant rate exceeds the national average. None of the cases reviewed evidence any judgement deficiencies or errors in applying the standards and procedures in effect at the time of the grant or disallowance. It has been suggested that the inherant nature of the disability often leads one to an isolated rural lifestyle such as this state offers, but this is only a supposition. What is clear is that in the overwhelming majority of PTSD claims, our psychiatric examiner provides an adequately supported diagnosis of Post Traumatic Stress Disorder. In the majority of those cases, the Veteran's specific stressor experience is able to be adequately "verified" and related to current symptomotology. As our mandate in such cases is to grant service connection for Post Traumatic Stress Disorder, we do so. The reason or reasons for our variance from the national average is therefore open to conjecture. The letter of 4-28-87 from the CBD to the Chief Medical Director states various possibilities for variance. (Letter attached)

A review of WIPP data indicates that some PTSD claims did not get input to SIRS. We are in the process of pulling these files and updating SIRS. Future COIN CP136 reports will furnish an updated analysis.

E.C. WILBERDING

ENC.

May 1987

SYSTEMATIC ANALYSIS REPORT
ADJUDICATION DIVISION
VARO, MUSKOGEE, OK

TYPE OF ANALYSIS: Unscheduled

SUBJECT OF ANALYSIS: Review of Post-Traumatic Stress Disorder Disallowances

MANHOURS REQUIRED: 12

PERIOD COVERED: March 1985/September 1986

DESCRIPTION OF ANALYSIS: A listing of PTSD cases rated at this regional office was requested and received from VACO C&P Service. From the listing, 104 of the cases were coded 1D, which means the RO decision was based on evidence from veteran/medical records and service-connection denied (DVB Circular 21-84-9). A random sample of 20 of these cases was selected from the list. The 20 cases selected were reviewed to determine reasons for disallowance, adequacy of the examinations, and any pattern by the examining psychiatrist.

FINDINGS: Dr. Larry Prater, Fee Basis Examiner, at the Oklahoma City VAMC performed the examinations in 9 of the 20 cases. Dr. Prater diagnosed generalized anxiety disorder in eight of the cases and depression in one case. Although Dr. Prater's examination reports were brief, they did include a history segment and a mental status exam.

On one exam, Dr. Prater found no relationship between the claimed stressor and the diagnosed anxiety disorder. In another claim, the exam report made no mention of a stressor in Vietnam, but the veteran claimed an alcohol problem since he was in Vietnam, so we put PTSD at issue on the 2507 request. In the third case the original exam was done by Dr. Sally Varghese. She diagnosed PTSD, but did not identify a stressor. The exam was returned as inadequate and the veteran was reexamined by Dr. Prater. Dr. Prater made reference to the veteran's claimed stressor of being a demolitions expert, but did not find the necessary diagnostic criteria to make a PTSD diagnosis. In the fourth case, the veteran had not identified a specific stressor, and none was noted on the NP exam. The other five cases were similar to the first four reviewed. In summary, the examination reports completed by Dr. Prater were brief, but did include a history segment and a mental status exam, and an attempt was made to link any claimed stressor to the veteran's current psychiatric disorder, if such a disorder was found. The exams were adequate for rating purposes.

Dr. Prater's association with the Oklahoma City VAMC as a fee basis examiner was terminated November 20, 1986, by the Chief of Community Medicine at that medical center.

Seven of the 20 cases reviewed contained psychiatric exams by Dr. Charles Cobb, M.D., Board Certified Staff Psychiatrist at the Tulsa Outpatient Clinic, which is a part of the Muskogee VAMC. Dr. Cobb's examinations generally contain a lengthy history segment, a thorough mental status exam, a diagnosis, and a discussion of how the diagnosis was reached.

One of Dr. Cobb's exams was actually an exam by a Board of Psychiatrists, which included Dr. Gary Lee, who is Chief of the Mental Health Clinic at VAMC Muskogee. Although the veteran had verified stressors (he is rated 50 percent for shell fragment wounds from combat in Vietnam), the Board of Psychiatrists found no evidence of any psychiatric disorder. The examination was thorough and entirely adequate for rating purposes. A subsequent exam was done on the veteran by Dr. Cobb after the veteran reopened his claim, with no psychiatric disorder found.

The second case reviewed with an exam by Dr. Cobb, was part of a POW protocol exam on a veteran who had been a POW in Germany for 21 days. Dr. Cobb said, "...he shows no affect consistent with PTSD." A diagnosis of life circumstance difficulties surrounding advancing age and a recent accident was made.

The third case, which involved an exam by Dr. Cobb, was on a veteran who has had problems with alcohol since age 5-6. A private hospital report includes an NP exam done April 6, 1985, with a diagnosis of alcohol abuse and dependency. Another private hospital exam of September 2, 1975, diagnosed antisocial personality. On VA exam of October 24, 1986, Dr. Cobb mentioned the general stressor the veteran claimed, but could find no clear cut stressors and no symptomatology of PTSD.

The other cases with exams by Dr. Cobb showed diagnoses of alcohol dependency, life circumstance problems, adjustment disorder, and no psychiatric disorder found.

Dr. Sally Varghese, Staff Psychiatrist at the Oklahoma City VAMC, examined one of the veterans in the sample. The veteran did not answer our PTSD development letter, and never identified a stressor to us or to Dr. Varghese. Even so, Dr. Varghese diagnosed PTSD without identifying a stressor. As a result, we disallowed the claim.

One case from the sample included an examination by Dr. Gagliano, D.O., of the Tulsa Outpatient Clinic. The veteran never identified a stressor in his claim nor was one identified in his rating exam by Dr. Gagliano, except for a reference to heavy combat. Dr. Gagliano found no evidence of a psychiatric disorder of any type in his examination of the veteran.

Dr. Gary Lee and Dr. Gail Johnson of the Tulsa Outpatient Clinic performed a joint examination on one veteran. The veteran had previously been diagnosed as having a cyclothymic personality, hypochondrial neurosis, and alcohol dependency. Dr. Lee and Dr. Johnson diagnosed life circumstance problems. The veteran's records show an Infantry M.O.S., Purple Heart, and Combat Infantryman's Badge.

The final case reviewed involved a veteran whose exam was done at VAMC Brentwood, California, before the file was transferred to VARO, Muskogee. The exam appears adequate for rating purposes, with a good history section and mental status exam. The Navy veteran claimed that he saw dead bodies in Vietnam. The Brentwood diagnosis was inadequate personality. His claim for PTSD was disallowed, and the disallowance has since been upheld by BVA on the basis that a chronic psychiatric disorder or PTSD has never been diagnosed.

CONCLUSIONS: In summary, the reason for disallowance if PTSD in 19 of the 20 cases was a failure of the examining physician to diagnose PTSD. In one case PTSD was diagnosed, but a stressor was not identified. All of the examinations were adequate for rating purposes, even through Dr. Larry Praters' exams were rather brief. I could find no obvious errors in the disallowance of PTSD in the 20 cases reviewed.

I have met with Dr. Gary Lee, Chief of the Mental Health Clinic at VAMC Muskogee and discussed the criteria for making a diagnosis of PTSD. We have had several discussions over the past year about particular cases, and PTSD claims in general.

In addition, Robert Carter, Rating Specialist, and I met on January 9, 1987, with Dr. Charles Smith, M.D. who is Chief of Staff at the Oklahoma City VAMC, and also a psychiatrist, and all members of the psychiatric staff of the hospital, including a newly recruited fee-basis psychiatrist. We had a lengthy discussion about PTSD and the diagnostic criteria found in DSM III and the Physicians Guide for Disability Evaluation Examinations. As a result of our visit, the NP examinations we are now getting from Oklahoma VAMC seem more thorough than ever before.

As PTSD Coordinator of this regional office, I now review each PTSD rating, before it is promulgated, to make sure that the exam is adequate and that Adjudication has properly developed and rated the case according to the guidelines we have. I have been reviewing all of these claims since December 1986.

I expect in due time our allowance rate of PTSD cases will be in line with the national average.

RECOMMENDATIONS: None

IS ASSISTANCE NEEDED FROM HIGHER AUTHORITY OR OTHER PROGRAM OFFICIALS: No

Gary Williams

SUBMITTED BY: Gary Williams
Adjudication Officer
Date: May 4, 1987

SYSTEMATIC ANALYSIS REPORT
ADJUDICATION DIVISION
VARO, MUSKOGEE, OK

TYPE OF ANALYSIS: Unscheduled

SUBJECT OF ANALYSIS: Review of Post-Traumatic Stress Disorder Allowed Claims

MANHOURS REQUIRED: 4

PERIOD COVERED: August 1981/August 1986

DESCRIPTION OF ANALYSIS: A listing of PTSD cases rated at this office was requested and received from the VACO C&P Service. From the listing, at 10 percent sample (six cases) was randomly selected from those coded on the list 1A. This code means service connection for PTSD was allowed by the RO based on evidence from veteran/medical records. The six cases were reviewed to confirm verified stressors, relationship to psychiatric findings, and adequacy of the examinations.

FINDINGS: One case involved a Korea POW for 33 months. The veteran was examined on an O&E basis at the Oklahoma City VAMC from February 10, 1986, to February 28, 1986. The report of the examination directly related the diagnosed PTSD condition to the veteran's POW experience.

The second claim was from a veteran who is service-connected for multiple gunshot wounds incurred in Vietnam. The psychiatric exam was done by a Board of Psychiatrists, consisting of Dr. Gary Lee, Chief of the Mental Health Clinic at VAMC Muskogee, and Dr. Charles Cobb, Staff Psychiatrist. The examination report included a lengthy history segment, which identified the stressors and other criteria diagnostic of PTSD. They stated their diagnosis of PTSD was consistent with the diagnosis made through the day hospital program.

The third case involved a World War II veteran who was awarded the Silver Star medal for heroism in 1945. PTSD was diagnosed by Dr. Larry Prater of the Oklahoma City VAMC on August 27, 1986, and confirmed in numerous out-patient treatment reports. In the NP exam, Dr. Prater lists the stressors of the veteran's combat experiences and also covers the other diagnostic criteria of PTSD. The exam was adequate for rating purposes.

The fourth case involves a veteran with an infantry M.O.S. who received the Combat Infantryman Badge in Vietnam. He was examined by Dr. Charles Cobb, who covered the stressors at length in the exam report. Dr. Cobb diagnosed PTSD and reported that the veteran, "...seems very preoccupied about Vietnam and experiences intrusive thoughts---hyperalertness, and a sense of guilt." The exam report was entirely adequate for rating purposes.

The fifth case reviewed was on a retired Army Sergeant. He was examined by Dr. Gary Lee. Dr. Lee's exam report discussed the stressors the veteran experienced in Vietnam, and the other criteria diagnostic of PTSD. The file also contains a write-up from two VA social workers who treated the veteran over a 2 year period, and several pages of progress notes from a VA Vietnam Stress Management Program. The diagnosis of PTSD is well supported by the evidence in the file.

The final case reviewed involved a Vietnam veteran who was a door-gunner on a helicopter. His VA exam was performed by Dr. John Bullen, M.D., who reviewed the veteran's C-file and Day Hospital treatment notes before making a PTSD diagnosis. The veteran related multiple stressors in the exam which are compatible with his verified duty as a gunner on a helicopter.

CONCLUSIONS: The six cases reviewed indicate that service-connection for PTSD is being allowed when properly diagnosed by a VA physician, and when the diagnosis is supported by other evidence in the veteran's records which tend to confirm the claimed stressors.

RECOMMENDATIONS: None

IS ASSISTANCE NEEDED FROM HIGHER AUTHORITY OR OTHER PROGRAM OFFICIALS: No

Gary Williams

SUBMITTED BY: GARY WILLIAMS
Adjudication Officer

Date: Aug 6, 1987

March 1984

POST-TRAUMATIC STRESS
DISORDER CLAIMS
VARO DENVER

The diagnosis and rating of PTSD claims in Colorado have been influenced by several factors, some of which may be unique to this state.

The Colorado Department of the Disabled American Veterans established a pilot program in the late 1970's to counsel Vietnam veterans in DAV Vietnam Veterans Outreach Centers. It became the model for outreach centers nationwide. Tom Williams, PhD., who began his clinical practice in Denver as a Counseling Psychologist for DAV, wrote the book, Post-Traumatic Stress Disorders of the Vietnam Veteran which was published in 1980. These two efforts focused attention on Denver, in the early development of PTSD claims.

Local policy decisions, in the form of Adjudication Officer memoranda, were pivotal in shaping the procedures and practices by which PTSD claims were addressed. The memos dated October 30, 1981, and October 5, 1983, were both significant (enclosed). As early as October 1981, we considered service department verification of certain MOS's, combat medals, and POW status as prima facia evidence of a stressor. While this memo did not relieve the Rating Specialists of the responsibility of confirming elicitation by the VA psychiatrist of a stressor, it facilitated the development of claims and led to the grant of many because all elements of the diagnosis were present, according to our policy.

The October 1983 memo was published after lengthy discussions with the physicians at the area VAMC's and the Rating Specialists. The physicians were eliciting life-threatening stressors, and providing the diagnosis, when the stressor could not be verified in place or time by the veteran's medical and personnel files. This caused misunderstanding and resentment among the veterans whose claims were eventually denied because we could not verify the stressor. Because the issue was both emotionally and politically sensitive, we agreed with the examining physicians to have record evidence of a stressor in the claims folder before a VA exam was scheduled. This procedure has been extremely effective in providing a unified position by the VAMC & VARO to the veterans. However, many claims that did not include private medical evidence, and the stressor could not be verified, were not disposed of by a rating decision, and therefore were not captured in the SIRS statistics. This invalidates the universe from which the number of claims granted is taken. We recognized this several months ago and disseminated a policy that all PTSD cases must be rated.

The PTSD diagnosis was also politically sensitive for the VAMC Denver, the hospital that does most of our VA exams. In 1983, the hospital was the subject of an investigation by a team from DM&S in Central Office because the American Legion alleged that the staff psychiatrists were not following published guidelines to assign a diagnosis of PTSD. Enclosed is a copy of the letter from Mr. R. E. Lynch of the American Legion to the Chief Medical Director. This investigation, no doubt, influenced the liberality of the psychiatrists in establishing the diagnosis.

The sampling of cases was thoroughly reviewed to determine the propriety of establishing service connection. In every case, we consider the diagnosis and the grant of service connection appropriate. The names and claim numbers of the cases that were sampled and the indicators that were applied are enclosed.

VETERANS ADMINISTRATION
Regional Office
Denver Federal Center
Denver, Colorado 80225

ADJUDICATION DIVISION
MEMORANDUM NO. 21-81-10

DATE: Oct. 30, 1981

SUBJECT: Post Traumatic Stress Claims

The following rules are for application in processing claims for Post Traumatic Stress Neurosis.

1. When a veteran claims post traumatic stress neurosis the file should be reviewed for the following indications of combat experience: Purple Heart: Combat Action Ribbon; Combat Medic Badge; Combat Infantry Badge; POW status; MOS of Infantry, Artillery, Armor, Combat Engineer; Helicopter Pilot or crew; Medic; or any other concrete evidence of a stressor in the service records. If any of these prima facia types of evidence exist, the claimant will be scheduled for a VA exam. The VAF 21-2507 will show post traumatic stress neurosis as the claimed condition.

2. If there is no evidence of combat experience or a life threatening situation in the veteran's records (as indicated in paragraph 1 above), a development letter will be sent to him (her) to elicit the information. If the evidence furnished supports the claim of a life stressor, a VA exam will then be requested. The VAF 21-2507 will show post traumatic stress neurosis as the claimed condition.

3. Whenever a diagnosis of this condition is received from a VAMC the completeness and appropriateness of the exam must be carefully considered under the provisions of PG 21-1, Section 0-12. Whenever an examination is incomplete, there should be no hesitancy in returning it as inadequate.

4. When a complete examination showing the disorder is received there should be no hesitancy in granting service connection absent inconsistent evidence in the claims folder.

R. L. McWilliams
R. L. MCWILLIAMS
Adjudication Officer

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Veterans Administration

Memorandum

Date October 5, 1983

To Rating Board Member

Subj Rating Practices

1. Post Traumatic Stress Claims

a. In new post traumatic stress claims, the Rating Specialists should not request a VAH examination until _after_ objective evidence of a stressor in service is documented in the claims folder (DVB Circular 21-82-7, para. a.). Once this is established, a diagnosis of the disorder will establish service connection if the diagnosis is otherwise acceptable for rating purposes, and the examination contains an adequate description of the stressor (see PG 21-1, Sec. 0-12).

b. Identification of a stressor (prior to requesting an exam) can be a very subjective process. Very careful review of all evidence in file is required, and there should be no hesitancy to request 201 file extracts, reports from the Agent Orange Task Force (Adjudication Officer's Memo 21-83-6) or to use the Vietnam Order of Battle.

2. Neurogenic Bowel and Bladder - This diagnosis when rendered by the VAMC, by its terms means a complete loss of natural function. It will be accepted as such absent clearly contradictory findings. If an apparent contradiction is noted, this should be brought to the personal attention of the Adjudication Officer for review prior to returning the exam to the VAMC.

3. Loss of Use of Buttocks - a finding of inability to rise from a sitting position without the use of external aids, which is due to disease or injury to muscle group XVII will be accepted as loss of use of buttocks.

R. L. CONLEE
Adjudication Officer

RLC/sc 10/5/83

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.ne
merican
Legion

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

August 8, 1983

Dr. Donald L. Custis (10)
Chief Medical Director
Veterans Administration
Washington, DC 20420

Dear Dr. Custis:

The American Legion and The American Legion of Colorado have developed serious concerns about the Psychiatric Service at the VAMC Denver.

In May of this year the Denver VAMC experienced two suicide attempts, one of them resulting in the death of the veteran, and the other in permanent injury. The American Legion has representation in both cases.

Mark D. Mansfield, on or about May 18, was seen by staff psychiatrists at the hospital and released. He proceeded from the doctor's office to the roof of the hospital and jumped to his death.

Rodney Heitzenrater was admitted to VAMC Denver several days following the Mansfield death and placed on a locked psychiatric ward. He proceeded to break a window and a suicide prevention screen and jumped, resulting in permanent physical injury.

In the Mansfield case the Legion is advising survivors to seek legal counsel concerning a possible action under the Federal Tort Claims Act. In the Heitzenrater case the Legion will file a claim under section 351 of title 38, USC, and recommend the family also seek legal counsel concerning a possible coincidental action under the Federal Tort Claims Act.

It would appear there is possible negligence in one or both of the above cited cases. Mansfield had been under the care of the VAMC Denver for some time and there is a definite responsibility to the physicians to protect the patient from himself. Heitzenrater was diagnosed as suicidal and placed on a locked ward for his own

.ection. The unanswered question is how could the patient break .rough a window and a suicide prevention screen without attracting the attention of the staff? The American Legion would like answers to these questions.

Additionally, we must advise you there is a continuing dissatisfaction by The American Legion of Colorado's representative with the quality of psychiatric examinations for rating purposes, performed by staff psychiatrists at VAMC Denver, especially with reference to Post Traumatic Stress Disorder. It is the opinion of our representative that the staff psychiatrists are not following pertinent guides and directives from Central Office with reference to the cited disability. The American Legion will not tolerate employees of the Veterans Administration who unilaterally decide that PTSD is not a valid psychiatric diagnosis. That issue has been settled and appropriate directives have been issued. Any VA employees who will not or cannot accept it should not be in VA service.

Presently The American Legion is presenting a series of cases from the Denver Regional Office to the Compensation and Pension Service on Administrative Review because we question the validity of the diagnoses made by staff psychiatrists at VAMC Denver.

Because of this problem and the two suicide attempts, which never should have happened on VA premises, it is our recommendation to the Chief Medical Director that an appropriate officer from the Department of Medicine and Surgery should be sent to VAMC Denver to investigate the quality of present staff and to take proper measures to insure there will be no repetition of the type of suicide attempts cited herein (it is reported there have been at least five other suicide attempts at the VAMC during 1983), and that VA staff physicians accept and adhere to the diagnostic procedures and directives provided by Central Office with reference to the clearly defined pathological condition of Post Traumatic Stress Disorder.

We will appreciate hearing from your office when the situation at VAMC Denver has been cleared up, and the proper treatment and security of veteran patients has been assured.

Sincerely,

R. E. LYNCH, Director
National Veterans Affairs and
Rehabilitation Commission

211B
211A

POST-TRAUMATIC STRESS DISORDER CLAIMS VARO DENVER

The diagnosis and rating of PTSD claims in Colorado have been influenced by several factors, some of which may be unique to this state.

The Colorado Department of the Disabled American Veterans established a pilot program in the late 1970's to counsel Vietnam veterans in DAV Vietnam Veterans Outreach Centers. It became the model for outreach centers nationwide. Tom Williams, PhD., who began his clinical practice in Denver as a Counseling Psychologist for DAV, wrote the book, Post-Traumatic Stress Disorders of the Vietnam Veteran which was published in 1980. These two efforts focused attention on Denver, in the early development of PTSD claims.

Local policy decisions, in the form of Adjudication Officer memoranda, were pivotal in shaping the procedures and practices by which PTSD claims were addressed. The memos dated October 30, 1981, and October 5, 1983, were both significant (enclosed). As early as October 1981, we considered service department verification of certain MOS's, combat medals, and POW status as prima facia evidence of a stressor. While this memo did not relieve the Rating Specialists of the responsibility of confirming elicitation by the VA psychiatrist of a stressor, it facilitated the development of claims and led to the grant of many because all elements of the diagnosis were present, according to our policy.

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The PTSD diagnosis was also politically sensitive for the VAMC Denver, the hospital that does most of our VA exams. In 1983, the hospital was the subject of an investigation by a team from DM&S in Central Office because the American Legion alleged that the staff psychiatrists were not following published guidelines to assign a diagnosis of PTSD. Enclosed is a copy of the letter from Mr. R. E. Lynch of the American Legion to the Chief Medical Director. This investigation, no doubt, influenced the liberality of the psychiatrists in establishing the diagnosis.

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Regional Office

Federal Building
125 South State Street
PO BOX 11500
Salt Lake City, UT 84147

Veterans Administration

December 16, 1986

Rec'd 12-29-86

In Reply Refer To

Director, Compensation and Pension Service (214A)
Veterans Administration Central Office
810 Vermont Ave, N.W.
Washington, D.C. 20420

SUBJ: Evaluation of Adjudication Division Compensation and Pension Operation

1. The material requested in your letter is enclosed.

PTSD

2. In response to your request, a sample of claim numbers of PTSD cases was obtained from Compensation and Pension Service (211-A). Review of six cases (a 10% sample) shows that stressors were verified through appropriate resources when benefits were granted. Psychiatric examinations continue to require our liaison with the VAMC to be sure individual psychiatrists follow all procedures. The inconsistency of grant percentage appears to be due to the clerical failure to enter all denials of PTSD into the SIRS system. A training class was held on December 4, 1986 to remind personnel to enter these cases into SIRS.

3. Station timeliness should continue at recent levels as we have now stabilized staffing levels following the substantial reductions in the last two years. A minor problem with delay time is being resolved through emphasis in this area as well as the addition of an intermittent development clerk who will be brought in to meet workload peaks and is equivalent to .1 FTE.

4. Station productivity should show improvement if corrections to the PAID and AMIS systems show properly the employment level in the division. Substantial inaccuracies in employment numbers occured during FY 86.

5. We anticipate no major operational changes once action is completed in filling the claims examiner position which has been vacant since November 9, 1986.

DOUGLAS WADSWORTH
Director

Enclosures

212 DAH:ag

"America is #1—Thanks to our Veterans"

Memo for Record

Post Traumatic Stress Disorder (PTSD)/Department of Medicine and Surgery (DM&S) Subcommittee

Los Angeles RO 3/23-25/86

Steve Petty MSW Loma Linda VAMC, Fred Gussman, MSW Palo Alto VAMC and Dr. Lawrence Kolb, distinguished VA Physician and Psychiatrist met at Los Angeles Regional Office with Mr. Herbert Mars, Deputy Director, Compensation and Pension Service (C&P).

The Regional Office (RO) was furnished with a list of PTSD cases from Central Office (CO) SIRS listing and randomly pulled each 5th file. They were then set up by OPC's doing VA C&P exams eg., Loma Linda; Brentwood, Sepulveda; Long Beach and Hill Street.

The task force reviewed the files to see what evidence was relied on for rating; the type of examination conducted, who conducted the exam (i.e., - MD, Psychiatrist, others) and the quality of the examination and diagnosis.

The group also interviewed separately, the RO PTSD Coordinator, two Rating Specialists and the two Rating Board Doctors.

SUMMARY OF RATING BOARD INTERVIEWS:

Statistically nationwide this station grants fewer PTSD claims and about the Lowest % Ratings.

Rating Board staff believe they had been very conservative in the past, but have improved. They have a few special problems. The greater % of claims, also involve alcohol/substance abuse. Diagnosis from OPC usually list that as the first diagnosis or combined with other diagnosis as the prime diagnosis.

The time constraints also affect them in that the major examining unit, Hill St OPC takes eight-nine months to complete exams and their exams are not the best, so returning exams as incomplete may mean over one year for rating.

The doctors complained about the exams also, and admitted being conservative in the past.

SUMMARY OF EXAMS

It appears examination guide lines need improvement.

Diagnosis should be clear and set forth what is causing the Veterans symptoms.

All parties agree a good social and industrial survey before exams would be helpful, but unlikley due to lack of staff and time needed to do the survey.

Coordination between departments needed since records of Inpatients, Vet Center Records and OPC are not coordinated and VSMC's and Rating Boards do not know such records exist unless such is specifically indicated.

FOLLOW up exams for Rating purpose were discussed.

Training media were also discussed such as video's for Physicians. The education subgroup will take this up on April 7th.

OTHER FINDINGS WERE:

Statistics had faults, since a high percentage of denials were for failure to report for exams.

Veterans Administration

Memorandum

Date June 9, 1988

From Adjudication Officer (21)

Subj Systematic Analysis of Operations

To Director (00)

1. AREA OF CONSIDERATION: Analysis of PTSD Claims

2. REFERENCE: Requested by C&P Service

3. PERIOD OF REVIEW: 1983

4. FINDINGS: A sample of 30 cases is estimated to be 10% of the total number of PTSD claims adjudicated and the findings are summarized below:

Number granted	9	(30%)
Number denied	21	(70%)
Total sample	30	(100%)

The sample consisted of:

WW II (1 POW)	2	6.67%
KC	3	10.00%
Career Servicemen	3	10.00%
VE	21	70.00%
PTE	1	3.33%
Total	30	100%

Of those claims in which SC was granted for PTSD, the documentation was as follows:

1	POW
4	GSW, SFW
2	Combat medals
1	Airplane accident
1	Combat MOS
9	Total

Of those claims in which SC was denied for PTSD, the following characteristics were revealed:

Five claims had a positive indication of a life threatening stressor:

a. KC vet gave a very vague history.
Diagnosis was Major Depression

b. VE vet gave no specific incidents of life threatening circumstances. Post service complicated by trouble with the law.
Diagnosis was Personality Disorder, Substance Abuse.

c. VE vet had lower extremity amputation from past service auto accident.
Diagnosis was Substance Abuse.

d. VE vet refused to be specific about combat duty.
Diagnosis was Dysthymic Disorders.

e. VE vet failed to cooperate.
No diagnosis.

Sixteen claims had no objective evidence of a life threatening stressor. The diagnoses werre as follows:

1	Schizophrenia
1	Bipolar Disorder
1	Dysthymic Disorder
1	Depression
12	Personality Disorder and/or Substance Abuse

5. CONCLUSIONS: This review supports the following conclusions:

A. Claims in which SC was established for PTSD are well documented.

B. A very small percentage of POW's file claims for PTSD. These are the claims that have a high probability of favorable action.

C. There is a high percentage of claims filed for PTSD which have no objective evidence of a life threatening stressor. (This may be a result of agressive solicitation of claims from Service Organizations and hospital VBC's from veterans in lengthly treatment programs for substance abuse).

F. G. RATHGEBER

BEST AVAILABLE COPY

St. Paul, MN

VETERANS ADMINISTRATION MEMORANDUM

Date: December 31, 1987

From: Adjudication Officer (21)

To: PTSD File

Subj: Review of PTSD Decisions - Central Office Request

1. A review was conducted of every tenth case on the Central Office computer listing of 279 PTSD claims considered here. A list of these 28 cases with associated data is attached. The review showed that service connection for PTSD was granted locally in 10 cases, or 37%, about the same as the overall station average. In another 11 cases (39%) a Veterans Administration medical diagnosis (psychiatric) was not shown. In 3 cases where the diagnosis was made it was not supported by the evidence of record. There were 3 grants by the Board of Veterans Appeals and one denial. The overall grant rate of the cases reviewed was 46%.

2. Other than the three cases where service connection was granted by the BVA the review by Division management showed no instances where the rating decision could be considered erroneous or contrary to basic rating principles. The appealed cases represented BVA judgment considerations and other factors and are beyond comment in the context of this report.

3. Any discussion of the subject-matter of this report should reference the information and constructive comments contained in memorandum of the Chief Benefits Director to the Chief Medical Director dated April 28, 1987 Central among such comments were the limitations of PTSD data base and reports, the many factors affecting the number and types of such claims received and the need to avoid unwarranted assumptions.

PTSD File

4. In summation this review did not reveal any meaningful or basic reason(s) for our variance from the national average. Nor does it appear that this variance, although 15 percentage points, is the result of improper procedures or lack of reasonable judgment in rating determinations. The denials were sound and based on applicable regulations and guidelines. In this connection it is noted that a specific review of PTSD cases here by Dean Kurtz of the Compensation and Pension Service last June reached essentially the same conclusion. (See Supplemental Report of Site Visit, August 7, 1987).

J. R. KELLEY
Adjudication Officer (21)
[illegible]

21/365 JRR:rf1158

PTSD CASES - REVIEW DECEMBER 1987

C NUMBER	GRANT	DENIED	BOARD OF SPECIALISTS
C 26 586 017	X		
C 12 313 320	X		
C 27 073 724		X (not shown)	
C 27 549 336	X (by BVA)		
24 756 903		X (not shown)	
27 347 700		X (not shown)	
29 651 414		X (Dx. not supported)	
SS 472-60-1748		X (not shown)	
26 580 962	X		
24 791 545	X (by BVA)		
28 255 333		X (by BVA)	
24 528 080		X (not shown)	
25 79[illegible] [illegible]		X (not shown)	
25 785 159	X		
SS 473-54-[illegible]	X		
05 410 440	X		
23 359 854		X (dx not supported)	
29 031 364		X (not shown)	
SS 472-60-7367		X (not shown)	
08 633 072	X		
24 791 575	X (by BVA)		
26 897 294	X		
28 300 098		X (not shown)	
25 707 591		X (not shown)	
25 897 084	X		
25 303 297		X (not shown)	
27 050 999		X (dx. not supported)	
25 299 431	X		

Veterans
Administration

Memorandum

Boston, MA

Date December 1, 1987

From Section Chief (211)

Subj PTSD Grant Rate - VACO Letter

To Adjudication Officer (21)

1. A review of 36 PTSD cases (5% of 710) was conducted. In all 36 cases the stressors, the relationship to psychiatric findings, and adequate findings to support the diagnosis were present. The medical facilities servicing this office, particularly the examining facilities, Northampton VAMC and Boston VAOPC, are well informed on findings necessary to support diagnosis of PTSD.

2. Objective evidence of stressors were documented as follows:

A.	DD 214	30 Cases
B.	DD Form 20	4 Cases
C.	Affadavit from Platoon Leader	1 Case
D.	None	1 Case

3. The case in which there was no objective evidence of stressor was done prior to DVB Circular 21-82-7 imposing this administrative requirement on PTSD grants. In this regard I point out session 1 problem & answer #3 (see attached) from 1987 VACO rating training package. This answer erodes the "objective" portion of this administrative requirement and seems contrary to the direction by VACO to perform this SAO.

4. In conclusion, the grants in all 36 cases were proper and followed directives in effect at the time of the decision. The high grant rate is ipso facto correct if it's individual components are correct. To speculate on the reasons for the 71.3% grant rate is just that, speculation. I would speculate the diagnosis is given by medical facilities based mainly on the veterans history.

5. The vast majority of cases reviewed showed objective evidence of stressor clearly present in the C-file. Combining this with diagnosis as outlined above equals a grant of claim.

JH Curran
D. SHAUGHNESSY
Section Chief (211) SECTION CHIEF (212)
Boston, MA
Concur: (21)

SPOT SAMPLE SIZE OF [illegible] PTSD CLAIMS • 36 CASES

VERIFIED STRESSOR	[illegible]	ADEQUATE EXAM
CIB + PH	YES	ADEQUATE
2 PH + CAR	YES	ADEQUATE
CAR + [illegible]	YES	ADEQUATE
CIB	YES	ADEQUATE
CAR + 2 PH	YES	ADEQUATE
PH	YES	ADEQUATE
CREW CHIEF ON HELICOPTER	YES	ADEQUATE
PH, BRONZE STAR Ē OLC	YES	ADEQUATE
PH	YES	ADEQUATE
CIB	YES	ADEQUATE
PH	YES	ADEQUATE
-POW	YES	ADEQUATE
HELICOPTER PILOT BSM, AIR MEDALS	YES	ADEQUATE
CAR	YES	ADEQUATE
CAR [illegible] BOMBING	YES	ADEQUATE
CIB	YES	ADEQUATE
CAR, BSM Ē V	YES	ADEQUATE
CIB	YES	ADEQUATE
[illegible]	YES	ADEQUATE
[illegible]	YES	ADEQUATE
3 PH	YES	ADEQUATE
[illegible]	YES	ADEQUATE
CAR	YES	ADEQUATE
AM Ē V	YES	ADEQUATE
AM Ē V	YES	ADEQUATE
CAR	YES	ADEQUATE
CIB	YES	ADEQUATE
[redacted]	[redacted]	[redacted]
[illegible] TO [illegible]	YES	ADEQUATE.
USM Ē [illegible]	YES	ADEQUATE.
CIB	YES	ADEQUATE
2 PH	YES	ADEQUATE
1982 GRANT	YES	ADEQUATE.
PH	YES	ADEQUATE
AM Ē 1 TOLC PH	YES	ADEQUATE

05-24-86 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 1 CUIN CP136

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO HVA TOTAL	REFERRED TO HVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VALO TOTAL	REFERRED TO VALO %
301	342	249	72.8	92	26.9	1	0.3					1	0.3
304	79	60	75.9	19	24.1								
306	416	183	44.0	233	56.0								
307	223	144	64.6	79	35.4								
308	127	73	57.5	54	42.5								
309	284	198	69.7	86	30.3								
310	546	203	37.2	343	62.8								
311	168	92	54.8	76	45.2								
313	130	65	50.0	65	50.0								
314	357	154	43.1	203	56.9								
315	167	87	52.1	80	47.9								
316	184	110	59.8	74	40.2								
317	639	381	59.6	258	40.4								
318	97	57	58.8	40	41.2								
319	71	32	45.1	39	54.9								
320	108	66	61.1	42	38.9								
321	63	33	52.4	30	47.6								
322	83	34	41.0	49	59.0								
323	86	41	47.7	45	52.3								
325	707	351	49.6	356	50.4								
326	113	44	38.9	69	61.1								
327	216	122	56.5	93	43.1	1	0.5	1	0.5				
328	158	104	65.8	54	34.2								
329	192	67	34.9	125	65.1								
330	538	306	56.9	232	43.1								
331	101	61	60.4	40	39.6								
333	102	50	49.0	52	51.0								
334	26	13	50.0	13	50.0								
335	119	51	42.9	68	57.1								
339	187	130	69.5	57	30.5								
340	62	35	56.5	27	43.5								
341	45	41	91.1	4	8.9								
343	245	133	54.3	112	45.7								
344	325	117	36.0	208	64.0								
345	199	140	70.4	59	29.6								
346	528	284	53.8	244	46.2								
347	94	71	75.5	23	24.5								
348	279	151	54.1	128	45.9								
349	292	107	36.6	185	63.4								

05-24-86 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 2 CUIN CP136

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO BVA TOTAL	REFERRED TO BVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
437	38	25	65.8	13	34.2								
438	45	26	57.8	19	42.2								
442	38	19	50.0	19	50.0								
452	93	62	66.7	31	33.3								
455	10	3	30.0	6	60.0	1	10.0	1	10.0				
460	11	1	9.1	10	90.9								
TOTAL	9797	5266	53.8	4522	46.2	7	0.1	5	0.1	1	0.0	1	0.0

05-24-86 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 1 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
301		72		85		46		15			23	241
304		21		14		15		2			8	60
306	2	45		74		35		12			10	178
307	5	39		53		29		4			11	141
308	2	23		15		6		3			24	73
309	2	67		75		33		2			11	190
310	2	86		69		22		6			11	196
311	10	45		29		3		2				90
313	3	24		23		10		2			2	64
314	7	58		45		24		2			18	154
315	2	17		40		23		2			5	89
316	4	42		23		20		5			14	108
317	7	105		108		66		17			56	359
318	4	23		19		6		1			1	54
319	3	18		4		3		1			2	31
320	6	31		18		8		1			2	66
321		9		8		7					4	28
322	1	14		11		5					1	32
323	5	10		12		5		3			2	37
325	1	95		131		62		26			17	332
326	2	17		12		6					6	43
327	6	21		44		17		2			28	118
328	7	56		29		6					4	102
329	4	32		18		8		2			2	66
330	2	62		118		62		14			40	298
331	6	23		20		8		1			2	60
333	1	34		10		2					3	50
334	2	6		2							2	12
335	6	20		14		8					4	52
339	12	48		45		15		2			8	130
340	4	7		10		7		2			4	34
341		8		17		9		4			1	39
343	20	72		24		10		1			5	132
344	23	56		20		6		1			3	109
345	4	69		40		9		3			6	131
346	62	80		44		42		12			13	274
347	5	37		20		4					2	66
348	2	35		77		27		2			6	149
349	3	35		24		29		5			16	107

05-24-86 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 2 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
437		7		11		3					3	24
438		12		9		1		1			2	25
442	1	7		4		1		1			4	18
452		16		21		8		2			9	56
455		1				2					1	4
460				1								1
TOTAL	225	1763		1690		807		193			434	5112

05-27-87 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 1 CUTN CP136

NO	TOTAL CLAIMS	APPROVED		DISAPPROVED		PENDING		REFERRED TO BVA		REFERRED TO ARMY		REFERRED TO VACO	
		TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%
301	654	464	70.9	189	28.9	1	0.2					1	0.2
304	172	129	75.0	43	25.0								
306	716	340	47.4	376	52.6								
307	466	288	61.8	176	37.8	2	0.4	2	0.4				
308	204	124	60.8	80	39.2								
309	561	391	69.7	169	30.1	1	0.2					1	0.2
310	942	401	42.6	541	57.4								
311	277	141	50.9	136	49.1								
313	223	118	52.9	105	47.1								
314	655	298	45.5	357	54.5								
315	338	191	56.5	147	43.5								
316	317	180	56.8	137	43.2								
317	1156	675	58.4	480	41.5	1	0.1	1	0.1				
318	192	118	61.5	74	38.5								
319	141	83	58.9	58	41.1								
320	235	143	60.9	92	39.1								
321	156	71	45.5	85	54.5								
322	168	69	41.1	99	58.9								
323	171	80	46.8	91	53.2								
325	1306	641	49.1	665	50.9								
326	207	84	40.6	123	59.4								
327	462	257	55.6	204	44.2	1	0.2					1	0.2
328	243	152	62.6	91	37.4								
329	312	132	42.3	180	57.7								
330	970	554	57.1	416	42.9								
331	275	158	57.5	117	42.5								
333	170	82	48.2	88	51.8								
334	68	29	42.6	39	57.4								
335	233	92	39.5	141	60.5								
339	382	268	70.2	114	29.8								
340	187	104	55.6	83	44.4								
341	80	71	88.8	9	11.3								
343	416	240	57.7	176	42.3								
344	658	217	33.0	441	67.0								
345	316	230	72.8	86	27.2								
346	969	564	58.2	405	41.8								
347	131	94	71.8	37	28.2								

05-21-87 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 2 CUIN CP136

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO RVA TOTAL	REFERRED TO RVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
437	57	35	61.4	22	38.6								
436	81	48	59.3	33	40.7								
442	84	33	39.3	51	60.7								
452	182	119	65.4	61	33.5	2	1.1	1	0.5			1	0.5
455	89	30	33.7	58	65.2	1	1.1					1	1.1
460	21	9	42.9	11	52.4	1	4.8			1	4.8		
TOTAL	18460	10040	54.4	8401	45.5	19	0.1	8	0.0	6	0.0	5	0.0

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05-27-87     REPORT 14      DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER      PAGE   1     COTN CP136

RO      0 %      10%      20%      30%      40%      50%      60%      70%      80%      90%      100%     TOTAL

301       6      107               169                99                25                          46       452
304       1       44                34                30                 5                          14       128
306       8       76               135                78                21                          22       340
307       9       88                94                61                10                          21       283
308       4       35                29                 9                 6                          39       122
309       7      130               144                68                11                          19       379
310       6      153               156                44                13                          20       392
311      14       79                36                 6                 4                                   139
313       6       36                43                20                 6                           5       116
314       9       98                93                51                10                          35       296
315       2       38                72                50                 7                          18       187
316       7       71                35                35                 7                          22       177
317      17      192               197               114                35                          88       643
318       5       49                39                11                 2                           5       111
319       6       38                16                12                 3                           7        82
320      11       69                41                14                 3                           6       144
321       1       24                20                15                                             4        64
322       3       30                21                 7                 3                           1        65
323       5       25                20                11                 7                           4        72
325       5      157               264               113                45                          41       625
326       3       40                23                 7                                             8        81
327       8       42                87                56                12                          49       254
328       8       82                44                10                 1                           5       150
329       8       57                41                17                 7                           5       135
330       4      108               197               130                35                          75       549
331      11       55                45                18                 4                           2       135
333       2       50                18                 6                                             3        79
334       6        7                 9                                   1                           4        27
335       9       32                28                12                 3                           5        89
339      16      101                95                30                 8                          18       268
340       9       39                18                21                 8                           6       101
341       1       18                24                15                 6                           5        69
343      31      116                59                21                 4                           5       236
344      41      119                40                 8                 4                           3       215
345      10      108                61                21                 5                          10       215
346      40      167               184                97                24                          32       544
347       9       42                32                 8                 1                           1        93
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05-27-87 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 2 CUIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
437		11		17		4					2	34
438	1	19		13		5		3			6	47
442	1	16		5		4		2			4	32
452		33		36		15		5			22	111
455		6		8		5		4			2	25
460	1	2		3		2		1				9
TOTAL	413	3217		3252		1625		449			830	9786

05-24-88 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 1 COIN CP136

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO BVA TOTAL	REFERRED TO BVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
301	938	672	71.6	264	28.1	2	0.2	1	0.1			1	0.1
304	276	205	74.3	71	25.7								
306	1053	527	50.0	526	50.0								
307	788	457	58.0	330	41.9	1	0.1	1	0.1				
308	277	162	58.5	115	41.5								
309	931	683	73.4	247	26.5	1	0.1					1	0.1
310	1276	581	45.5	695	54.5								
311	435	244	56.1	191	43.9								
313	297	151	50.8	146	49.2								
314	982	460	46.8	522	53.2								
315	549	308	56.1	241	43.9								
316	532	313	58.8	219	41.2								
317	1851	988	53.4	861	46.5	2	0.1	2	0.1				
318	317	188	59.3	129	40.7								
319	265	158	59.6	107	40.4								
320	420	240	57.1	180	42.9								
321	317	152	47.9	165	52.1								
322	334	129	38.6	204	61.1	1	0.3	1	0.3				
323	320	171	53.4	149	46.6								
325	1799	896	49.8	902	50.1	1	0.1	1	0.1				
326	314	118	37.6	196	62.4								
327	711	393	55.3	317	44.6	1	0.1					1	0.1
328	422	254	60.2	168	39.8								
329	411	181	44.0	230	56.0								
330	1399	775	55.4	624	44.6								
331	430	235	54.7	195	45.3								
333	242	115	47.5	127	52.5								
334	108	49	45.4	59	54.6								
335	316	127	40.2	189	59.8								
339	669	454	67.9	215	32.1								
340	320	168	52.5	152	47.5								
341	151	117	77.5	34	22.5								
343	743	446	60.0	297	40.0								
344	1004	339	33.8	663	66.0	2	0.2	2	0.2				
345	614	442	72.0	172	28.0								
346	1472	866	58.8	606	41.2								
347	203	137	67.5	66	32.5								
348	802	405	50.5	397	49.5								
349	965	416	43.1	549	56.9								
350	352	213	60.5	139	39.5								
351	452	191	42.3	261	57.7								
354	56	20	35.7	36	64.3								
359	262	197	75.2	65	24.8								
362	284	142	50.0	142	50.0								
363	83	63	75.9	20	24.1								
369	2	2	100										
372	48	24	50.0	24	50.0								
373	374	268	71.7	104	27.8	2	0.5	2	0.5				
377	454	231	50.9	223	49.1								
402	374	230	61.5	134	35.8	10	2.7	3	0.8	7	1.9		
405	125	92	73.6	33	26.4								

05-24-88 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 2 COIN CP136

RO	TOTAL CLAIMS	APPROVED		DISAPPROVED		PENDING		REFERRED TO BVA		REFERRED TO ARMY		REFERRED TO VACO	
		TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%
436	113	61	54.0	52	46.0								
437	89	59	66.3	30	33.7								
438	110	63	57.3	47	42.7								
442	119	45	37.8	74	62.2								
452	392	238	60.7	152	38.8	2	0.5	2	0.5				
455	169	66	39.1	102	60.4	1	0.6					1	0.6
460	60	30	50.0	29	48.3	1	1.7			1	1.7		
TOTAL	29171	15957	54.7	13187	45.2	27	0.1	15	0.1	8	0.0	4	0.0

05-24-88 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 1 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
301	10	158		234		136		37			70	645
304	1	51		61		57		5			27	202
306	16	113		184		135		36			41	525
307	14	127		169		86		21			40	457
308	8	45		35		18		11			43	160
309	10	182		311		113		22			27	665
310	6	218		223		68		21			25	561
311	30	142		51		10		7				240
313	9	41		45		36		10			8	149
314	11	142		150		80		14			57	454
315	4	51		121		79		14			32	301
316	15	113		65		50		13			46	302
317	29	281		289		149		54			141	943
318	6	78		62		20		2			9	177
319	9	61		33		23		5			17	148
320	13	111		70		25		7			10	236
321	3	54		48		26		1			7	139
322	4	59		41		15		2			2	123
323	6	53		47		27		12			13	158
325	6	226		346		155		57			70	860
326	3	57		32		8		1			12	113
327	17	71		138		75		16			72	389
328	13	129		82		18		2			7	251
329	15	83		49		22		5			9	183
330	8	147		280		169		42			113	759
331	19	86		60		27		5			6	203
333	4	55		38		12		1			4	114
334	9	19		11		1		1			4	45
335	12	45		39		17		5			7	125
339	22	171		148		61		14			33	449
340	15	66		33		30		12			10	166
341		25		40		26		12			9	112
343	51	212		120		35		8			7	433
344	56	186		73		13		7			7	342
345	21	215		104		35		9			16	400
346	67	268		268		144		38			47	832
347	15	64		43		11		2			1	136
348	9	101		184		64		21			14	393
349	9	77		110		98		28			79	401
350	5	22		62		52		30			39	210
351	7	56		35		31		11			43	183
354	2	11		5		1					1	20
359	22	89		53		20		7			8	199
362	21	44		28		17		6			17	133
363	5	18		18		14		2			6	63
369		1		1								2
372		6		4		8		1			4	23
373	3	57		111		51		17			27	266
377	10	92		77		33		8			6	226
402	17	62		65		40		15			31	230
405	2	23		34		12		5			12	88

05-24-88 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 2 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
436	2	31		18		5		2			3	61
437	1	25		21		5					6	58
438		21		15		11		4			11	62
442	3	17		13		3		5			3	44
452	11	54		69		35		16			39	224
455	4	11		15		13		9			7	59
460	1	4		9		10		4			2	30
TOTAL	691	5027		5090		2535		722			1407	15472

Department of Medicine
and Surgery

Washington D.C. 20420

Veterans
Administration

OCT 0 4 1988

In Reply Refer To: 116

Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United State Senate
Washington, DC 20510

Dear Mr. Chairman:

This is a reply to your letter of August 17, 1988, which requested a summary of what is being done or being planned regarding the implementation of 97 recommendations incorporated in the first three Annual Reports of the Special Committee on PTSD.

I have enclosed a white paper which will give you a complete overview of the VA's response to the Special Committee's Annual Reports. These Annual Reports contain a total of 98 recommendations, of which 83 (85% of all recommendations) have been or are being implemented. Of the 15 recommendations not implemented, several have been repeated so that only 11 actual recommendations have not been implemented. Five of these non-implemented recommendations are in the area of research where a significant increase in activity related to PTSD has taken place. All of the recommendations relating to the direct clinical care of veterans with PTSD have been implemented with the sole exception of the expansion of Vet Center services for veterans of other combat eras.

Thank you for the opportunity to provide this information.

Sincerely,

John A. Gronvall
JOHN A. GRONVALL, M.D.
Chief Medical Director

Enclosure

"America is #1—Thanks to our Veterans"

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY

STATUS OF RECOMMENDATIONS MADE BY SPECIAL COMMITTEE ON PTSD

The First Annual Report (1985) contained 32 recommendations. (It must be noted that the recommendations were numbered from 1 to 33 but this was due to a typographic error which skipped the number 26. There were two recommendations under "Resource Allocation." The first suggested the establishment of PTSD Treatment Teams in all VA Medical Centers. This has been initiated with the establishment of 15 PTSD Treatment Teams in FY 1987 and with current plans for the establishment of 10 to 12 more PTSD Treatment Teams using funds appropriated through P.L. 100-404, the 1989 Appropriations Act for HUD and Independent Agencies. It is our belief that every VA Medical Center does not require the presence of a PTSD Treatment Team. The second recommendation was that the VA establish a PTSD Treatment Unit in each of the VA's Medical Districts. This recommendation is in the process of being implemented: between Specialized Inpatient PTSD Units, PTSD Treatment Teams, and PTSD outpatient programs, there is currently at least one designated PTSD program in 20 of the VA's 27 existing Medical Districts.

Four recommendations (#3-#6) were listed under "Clinical Data Acquisition." The first recommendation in this section was that the VA establish a tracking system throughout their inpatient and outpatient care components and the second recommendation urged an accelerated timetable for the implementation of clinical software packages for the VA's automated data processing (ADP) system to facilitate tracking. Neither of these recommendations has been fully implemented. Progress has been made in inpatient data collecting capability, but it has not been fully established for outpatient care. Competing priorities have delayed the establishment of this tracking capability. Latest estimates suggest that medical record tracking capability will begin to be installed in December 1988 and be completed in September 1989. The third recommendation was that the data tracking system assess treatment outcome. While we have concurred with this recommendation, the incorporation of treatment outcome data is not a part of any existing VA data base. This is an innovative concept that is currently being stressed in pilot programs guided by Mental Health and Behavioral Sciences Service such as the Homeless Chronically Mentally Ill (HCMI) Veterans Program and the Region I Mental Health Initiatives Project. To help implement P.L. 100-404, a comprehensive evaluation of treatment provided to veterans in Specialized PTSD Inpatient Programs, in PTSD Outpatient Programs and through PTSD Treatment Teams will be developed. The fourth recommendation in this section, the one that has been fully implemented, was that an epidemiological and demographic study of veterans with PTSD being cared for by VA Medical Centers, Outpatient Clinics and Vet Centers be performed. The results of this study have been reported in the Special Committee's Third Annual Report (1987).

Three recommendations (#7-#9) were made under the heading "Improving Access to Care." Recommendation #7 was that adequate diagnosis be provided for combat veterans regardless of service-connected status, and this is being done. Recommendation #8 was that a standardized protocol be developed to identify patients at risk for PTSD, and this is in the process of implementation through DM&S Circular 10-87-52 on PTSD diagnosis as well as through the mechanism of Program Guides on the treatment of PTSD which should be published in FY 1989. The ninth recommendation was that combat veterans be assessed for PTSD regardless of priority for care as defined locally. To a significant degree, this recommendation is being implemented in the same manner as Recommendation #7 by means of continuing education for VA staff on the diagnosis and treatment of PTSD and the requirement that patients in need of care be evaluated regardless of service-connected status.

Under the heading "Diagnosis of PTSD" three recommendations (#10-#12) were made and all have been implemented. Recommendation #10, for increased guidance in diagnosis of PTSD, has been implemented by DM&S Circular 10-87-52 and by continuing PTSD education. Recommendation #11, for the development of PTSD rating scales, has been implemented and Circular 10-87-52 references several of the more popular rating scales. Recommendation #12, calling for education in psychological and physiological techniques in PTSD diagnosis, has also been carried out through training programs at the Regional, Medical District and Medical Center levels.

Under the heading "Treatment", five recommendations (#13-#17) were made, all of which are in the process of implementation. Recommendation #13 is for the development of Mental Health Program Guides for PTSD. These guides, one for PTSD Treatment in General Psychiatry and one for Specialized Inpatient PTSD Units, are being developed and should be in the field in FY 1989. The Program Guides will also satisfy Recommendation #14 which called for the development of criteria for referral of patients to specific PTSD treatment programs. Recommendation #15, was for a specific DRG or pass through status for PTSD. The Department of Medicine and Surgery (DM&S) and the VA RAM Task Force are currently reviewing a proposed revision of psychiatric DRG's which includes special provisions for PTSD. This new classification system will be pilot tested at 12 VA medical centers during FY 1989. Recommendation #16, on adequate staffing for consultation/liaison services, is being implemented through the establishment of PTSD Treatment Teams. Recommendation #17, for systematic coordination and integration of VA treatment services including Vet Center activities, is being implemented and is reinforced through continuing education.

Recommendations #18-#21 came under the heading of "Research"; two have been implemented and two have not. That PTSD research remains a high priority for the VA (Recommendation #18) is demonstrated by the increase in funding for PTSD research from 1986 to 1987, as reported in my testimony to the Senate Veterans Affairs Committee on July 14, 1988. Recommendation #19, requesting special funding for PTSD research, has not been implemented because of our policy that research projects should be funded on the basis of merit and peer review, rather than by topic. Recommendation #20, for a repeat of the 1984 workshop on PTSD research has not been implemented because of budgetary constraints. Recommendation #21, urging awareness and expertise in PTSD on the Mental Health and Behavioral Sciences Merit Review Board, has been implemented. Dr. Terence Keane, Chief of Psychology Service at VA Medical Center, Boston, Massachusetts, served on the Board for three years. He is a recognized leader in PTSD research. Dr. Patricia Sutker, Chief of Psychology Service, VA Medical Center, New Orleans, Louisiana, is also highly respected in the area of PTSD research and has recently been appointed to serve a three year term on the Mental Health and Behavioral Sciences Merit Review Board. There were five recommendations (#22-#25, #27) under "Education," all of which have been and continue to be implemented. Recommendation #22, urged a national approach to PTSD training. This is being insured through the PTSD Education Committee which is composed of staff from VA Central Office and the Special Committee on PTSD. Designation of PTSD as a national education focus with special funding for FY's 1985, 1986, 1987 and 1988 also reinforced implementation of this recommendation. Recommendation #23 urged assessment of the impact of PTSD education which has been done by both the Special Committee, which has documented an increase in PTSD diagnosis following PTSD education and the Office of Academic Affairs' program assessments. Recommendation #24 was for the identification of faculty for PTSD education programs which has been done and which is continuing. Recommendation #25, for central direction of PTSD education, has been realized by the PTSD Education Committee cited above. Recommendation #27 (please recall that there is no #26) suggests five target audiences for PTSD education; VA clinical and administrative staff, military personnel, community groups and students of the health professions. Some work has been done with all of these groups although the major emphasis has been on VA staff and students.

The final section of the First Annual Report, "Veterans Benefits Issues" included Recommendations #28-#33. Recommendation #28 has not only been met, it has been exceeded: the Special Committee asked for a three month survey of PTSD claims adjudication but a one year survey was carried out and reported to the Committee. A tracking system for PTSD claims (Recommendation #29) is in place. Recommendation #30 stated that adjudication boards give presumptive accuracy to a clinical diagnosis of PTSD with verification of the stressor required only in questionable cases. This recommendation has not been implemented since it is contrary to the Department of Veterans Benefits' practice requiring verification with regard to all types of disability. Recommendation #31, for joint training of adjudicators and clinicians, has been implemented as has Recommendation #32, urging adjudicators to consider all relevant clinical information in claims decisions. Recommendation #33, that a PTSD coordinator be designated at each DVB Regional Office, has also been implemented.

In summary, of the 32 recommendations of the First Annual Report, 19 have been implemented, 10 more are in the process of being implemented and three have not been implemented.

The Special Committee on PTSD's Second Annual Report (1986) contained five general recommendations, all of which have been or are being implemented. Chapter 3 of the Report included 42 recommendations on the establishment and management of Specialized Inpatient PTSD Units (SIPUs) which will be incorporated into the Program Guide for Specialized Inpatient Units (1989). Imbedded in the text of Chapters 6-10 of the report were 27 additional recommendations, many of which were similar to the recommendations of the First Annual Report.

Regarding the five general recommendations, the first two, the establishment of PTSD Treatment Teams and the development of standards and evaluation for SIPUs, are both in the process of being implemented as noted above. The standards will be published in the Program Guides and will form the basis for program evaluation of SIPUs beyond that already done for these units as part of Psychiatry Service. The last three general recommendations have all been implemented. They were: a study of numbers and demographics of patients treated for PTSD in outpatient and inpatient services (reported in the Special Committee's Third Annual Report); targeting VA medical centers perceived as having a disproportionately low frequency of diagnosing PTSD for PTSD education (implemented in 1987 and 1988); and continued monitoring of adjudication of PTSD claims.

Chapter 6, "Screening for PTSD", had two recommendations: that there be a question on the 10-10M (patient initial screening form) on combat exposure and that a positive response trigger further evaluation of the patient for combat related problems such as PTSD. These recommendations have been implemented through the inclusion of military history and combat exposure items on the computerized Medical Administration Service software package, by a circular (DM&S 10-88-22) and education on the importance and nature of the military history and by including the military history as a required item for completion in the medical record as part of VA Systematic External Review Program (SERP) surveys. Chapter 7, "Methods for Psychological Assessment of PTSD" included 8 recommendations for a basic PTSD exam and a recommendation for a brief PTSD evaluation extracted from elements of the basic exam. The 8 basic exam elements are: clinical interview, structured interview for PTSD, military history and pre-post military adjustment, mental status exam, psychometric evaluation, combat experience scale, psychophysiological assessment, information from archival records (military/medical) and information from significant others. All these recommendations have been implemented through several mechanisms including DM&S Circular 10-87-52, continuing PTSD education and planned incorporation in the Program Guides.

Chapter 8, "Research", had five recommendations. The first was a repetition of the request to maintain PTSD as a high priority for VA research. This, as noted above, has been implemented. The last four recommendations in this section have not yet been implemented pending availability of resources. These recommendations were: a repeat of the 1979 request for proposals on PTSD research; support for attendance at a mini-residency at the University of Michigan on research design; special research training for staff of the Specialized Inpatient PTSD Units; and a repeat of the Special PTSD Research Training program.

Chapter 9, "Education", had five recommendations. The first recommendation, for formal identification of faculty for VA training, was implemented, and a list was developed. In practice this list has not seen much use since the PTSD Education Committee and the local Regional Medical Education Centers (RMECs) are already aware of subject matter experts in the field. The second recommendation was not truly a "recommendation" but rather it was more a comment on allocation of training funds on PTSD for Vet Centers and other DM&S programs. Further monitoring of education and integration of medical center and vet center training activities has continued. The third recommendation repeated the need for education on PTSD for five major audiences, as listed in First

Annual Report Recommendation #27. As noted above, this is being done. PTSD Treatment Teams have been particularly active in education for the community and for students. The fourth and fifth recommendations repeated the need for targeting areas with a low incidence of PTSD diagnosis for education and the need for assessment of the impact of PTSD education. Both of these recommendations have been and continue to be carried out.

Chapter 10, "Veterans Benefits", had six recommendations, four of which were implemented. The third recommendation which was not implemented, suggested that comparable data be submitted on adjudication of claims for psychiatric diagnoses other than PTSD, for purposes of comparison. This could not be done because of the workload increase such activity would impose on DVB, especially in view of staffing cuts. The sixth recommendation, that information from the adjudicators' Spring training be forwarded to the Special Committee, could not be implemented because that training had not yet taken place. PTSD was included in the agenda of the September 1987 adjudicators meeting. The four recommendations which were implemented included: continuation of the PTSD tracking system; identification of adjudication data submitted to the Special Committee by Regional Office; review of Regional Offices that appear to be high or low outliers with regard to approval/disapproval rates; and continuation of joint DM&S, DVB training on PTSD.

In summary, the Second Annual Report had all five general recommendations and 21 of the 27 chapter recommendations implemented; 6 recommendations were not implemented.

The Special Committee's Third Annual Report (1987) had 39 recommendations of which 33 have been, or are being implemented.

Under "Strategic Planning and Resource Allocation", there were two recommendations, both of which are being implemented. Recommendation #1 is that the PTSD data base represented by the Third Annual Report be used in strategic planning and PTSD resource allocation. This recommendation has been further promoted by the Special Committee's distribution of the data base to the Regional Directors in 1988. The second recommendation, to improve the consistency of PTSD treatment in the VA is being promoted by continuing VA-wide PTSD education and will be reinforced by the publication of the Program Guides.

The section on "PTSD Treatment Teams" had three recommendations (#3-#5), all of which are in the process of being implemented. Recommendation #3 urged a five year timetable for establishing

PTSD Treatment Teams in all VAMCs. While we do not believe that all VAMCs require Treatment Teams, the "second wave" of 10 to 12 teams will be placed in FY 1989. Recommendation #4, on monitoring the activity and productivity of Treatment Teams is being done and continues to be enhanced. Recommendation #5, on criteria for placement of new Treatment Teams, will be met by involving the Special Committee more deeply with the site selection process for the 1989 Treatment Teams; and VA Medical Centers will be invited to submit applications for funding these PTSD Treatment Teams through an RFP process.

The section on "Special Inpatient PTSD Units" had two recommendations, (#6 and #7) which repeated the request for establishing standards of care through the Program Guides and review of funding strategies for SIPUs under the VA's Resource Allocation Methodology (RAM). As noted above, both of these recommendations are being implemented.

The "Vet Centers" section contained 13 recommendations (#8-#20), all but one of which are in implementation. The recommendations included: incorporation of Vet Centers into the DM&S organizational matrix; review of the Vet Center mission, establishment of goals and policy guidance for Readjustment Counseling Service and Vet Centers; (the new Vet Center Program Guide was published in January 1988); career appointments for Vet Center staff; productivity standards and data for Vet Centers; standards of care and quality assurance for Vet Centers; comprehensive outreach and case management; more comprehensive and sophisticated diagnosis and treatment; identification of medical problems in Vet Center clients; aggressive outreach to female and minority veterans; enhanced communication and collaboration between Vet Centers and VA Medical Centers; and increased clinical supervision and sharing of productivity data with Vet Centers. Recommendation #14, that legislative authority be sought to expand eligibility for Vet Center services to veterans of all combat eras has not been implemented. The Agency currently supports extension of this eligibility to post Vietnam era combat veterans.

The section on "Clinical Data Acquisition" had three recommendations (#21-#23). Recommendations #21 and #22, for repetition of the inpatient and outpatient PTSD survey in FY 1987, were not implemented due to the cost implications. (Further analysis of the existing PTSD data base is being performed.) Recommendation #23, urging timely completion of the National Vietnam Veterans Readjustment Study conducted by the Research Triangle Institute, has been implemented. Preliminary data from the Study have been provided to the Agency and have been reported to Congress. The full report is expected by November 1988.

Three Recommendations (#24-#26) were made in the "Treatment" section. Recommendation #24, completion of the Program Guides on PTSD, is being implemented with completion expected in FY 1989. Recommendation #25, increased communication, coordination and combined education between VAMCs and Vet Centers, is also being implemented as an ongoing process. Recommendation #26 noted the relatively low incidence of reported PTSD in outpatient alcohol and drug programs. Exploration of this phenomenon and education on the interaction of substance abuse disorders and PTSD have been implemented.

Only one recommendation (#27) was made under "Identifying Veterans at Risk for PTSD," a repetition of the request to record combat information on "10-10M" forms. The implementation of action to meet this request has been described above.

The "Research" section had two recommendations (#28 and #29). They repeated the requests for financial incentives to priority research and the suggestion of a special request for research proposals on PTSD. Neither recommendation has been implemented for the reasons cited above, though, as also noted above, VA research on PTSD has increased significantly in recent years without these special provisions.

The "Education" section had three recommendations (#30-#32), which repeated previous recommendations. These have been implemented. The recommendations include: a national approach on PTSD education; a national faculty and updating of education materials on PTSD; and targeting of areas with low frequency of PTSD diagnosis for PTSD education.

The final section, "Veterans Benefits Issues," had seven recommendations (#33-#39), with implementation of all but one. The recommendation not implemented was #37, a repeat of the request that DVB reconsider its standards for establishing evidence of a stressor in patients whom clinicians have unequivocably diagnosed as having PTSD. The rationale for not implementing this recommendation has been noted above. The recommendations that have been implemented include: continued monitoring by DVB of the adjudication and appeals process regarding PTSD claims; continued review of approval/disapproval rates at the Regional Office level; sharing of information on Board of Veterans Appeal (BVA) actions and DVB Regional Office reviews with the Special Committee; sharing of information on errors in the adjudication process with DVB Regional Offices; awareness of the need for providing a supportive clinical environment in situations where questions to a veteran elaborating on a PTSD stressor is anticipated as being significantly distressing; and ongoing outreach to veterans suffering from PTSD.

In summary, 33 recommendations from the Third Annual Report have been or are being implemented. Of the 6 recommendations not implemented, three are repeats of prior, non-implemented recommendations.

Department of Medicine and Surgery
Washington D.C. 20420

Veterans Administration

A'G 1 2 1988

In Reply Refer To: (116A1)

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Mr. Chairman:

At the July 14, 1988, Committee hearing on the treatment of Post Traumatic Stress Disorder (PTSD) in the Veterans Administration, we were asked to submit by July 27, 1988, information on the proposed administrative structure for the new National Center for PTSD. This was done and a copy of the information on the administrative structure and reporting requirements for the National Center is enclosed.

The National Center for Stress Recovery at the VA Medical Center, Cleveland, Ohio (Brecksville Division), was so designated in 1984. It was site-visited in 1987 by representatives of the Chief Medical Director's Special Committee on PTSD and Mental Health and Behavioral Sciences Service staff from VA Central Office. While it was necessary to allow time for the program to be established, concern about the lack of progress in the development of research and the limited educational activity of the Center for Stress Recovery, made the need for a thorough review of the Center evident. The 1987 site visit and subsequent review of the site visit report in VA Central Office, confirmed that the center had to be replaced.

The site visit report, the recommendations of the Special Committee on PTSD, and the VA Central Office review of these, resulted in the identification of several actions required to promote the optimal functioning of the new National Center for PTSD. The new National Center for PTSD should serve as the cornerstone for research, clinical evaluation and education. First, the new National Center for PTSD will be identified through a Request For Proposal (RFP) process with submissions reviewed by a committee of experts from VA Central Office and the field. This review committee will include members from Mental Health and Behavioral Sciences Service, Readjustment Counseling Service, the Office of Academic Affairs, the Office of the Assistant Chief Medical Director (ACMD) for Research and Development and the Special Committee on PTSD. We believe this process will be more thorough than that which established the first center. Additionally, there are requirements for applicants in the RFP process that should improve the likelihood of a strong and effective National Center. These include requirements for an established PTSD clinical program, proven expertise in treatment, research and training in PTSD, and, active support by an affiliated medical school with an interest in PTSD.

Page 2.

Honorable Alan Cranston

Second, the administrative structure and reporting requirements for the National Center, as described in the enclosed document, are designed to allow the National Center to function as an integrated component of the host VA Medical Center and still have the benefit of oversight and support from VA Central Office. Responsibility in VA Central Office will reside with the Associate Deputy Chief Medical Director. The ACMD for Clinical Affairs and the Director, Mental Health and Behavioral Sciences Service, will also closely monitor the National Center's progress.

Currently, the Special Committee's recommendations concerning funding for the National Center are being reviewed. This issue will be evaluated carefully and a decision on the amount of funding for the Center will be made prior to the release of the RFP to the field this month.

In summary, it is our intention that the new National Center for PTSD become a successful and significant component of VA leadership in education, research treatment of this disorder.

Sincerely,

John A Gronvall

JOHN A. GRONVALL, M.D.
Chief Medical Director

Enclosure

NATIONAL CENTER FOR PTSD

1. Administrative Structure: The National Center on Post Traumatic Stress Disorder (PTSD) as an integral part of the host Medical Center will report to the VA Medical Center - Chief of Staff, to the VA Medical Center Director and to the Regional Director. From the Regional Director, the reporting responsibility in VA Central Office will be to the Associate Deputy Chief Medical Director.

(a) The Chief Medical Director's Special Committee on PTSD will advise the Chief Medical Director on all aspects of the treatment of PTSD of which the National Center on PTSD is an especially focussed part addressing Research and Education.

(b) The Director of the National Center on PTSD will be appointed after the advice of the Director of Mental Health and Behavioral Sciences Service (MH&BSS) and the Chief Medical Director's Special Committee on PTSD has been sought and considered.

2. Reporting Requirements: To insure and document that the National Center on PTSD is meeting its Congressionally mandated goals, the program will have the following reporting requirements.

(a) Quarterly reports from the Director of the National Center, to the Director, MH&BSS, on the Center's research, education, and clinical activities. The reports will cover both the status of ongoing activities and the development of new activities. After the first year of the Center's operations, reports will be submitted no less than every six months, and more frequently if the Director, MH&BSS considers it necessary.

(b) During the first year of operation, the Center Director will meet quarterly with the Director, MH&BSS to report on implementation. Subsequently, the Director will meet at least biannually with the Director, MH&BSS.

(c) Every two years one meeting with the Director, MH&BSS will involve a site visit to the Center.

(d) Annually, the Center Director will submit a comprehensive report on the Center to the CMD's Special Committee on PTSD, timed so as to allow for review and inclusion in the Special Committee's Annual Report to Congress.

Enclosure

The Department of Veterans Benefits (DVB) and the Department of Medicine and Surgery (DM&S) have recently issued circulars on Post-traumatic Stress Disorder (DVB Circular 21-86-10, 9/86 and DM&S Circular 10-87-52, 6/87). DVB and DM&S coordinated their efforts in the creation of these circulars, copies of which are attached.

Since FY 1987, a number of major training activities on PTSD have taken place involving DM&S and DVB staff. This has included training in VA DM&S Region 3 (2/87) and Region 7 (5/87) for Chiefs of Psychiatry, Psychology, Nursing and Social Work; Vet Center staff and DVB personnel. In addition, the Associate Director for Psychiatry, Mental Health and Behavioral Sciences Service has presented on the Diagnosis and Evaluation of PTSD to the DVB Adjudicators meeting in 9/87 and to the Bureau of Veterans Appeals (BVA) staff retreat in 5/88. DVB has also carried out some field-level training on PTSD for its staff. Currently, DM&S and DVB staff with members of the Chief Medical Director's Special Committee on PTSD, are planning a training module on PTSD examinations for physicians who perform compensation and pension examinations, as a method of improving the quality of these examinations.

These measures are not perceived as resolving all issues between DM&S and DVB on PTSD, rather they are steps in an ongoing and continuous process of monitoring and improving evaluation and compensation procedures for PTSD.

C&P EXAMINATION UPDATE

Last July, representatives from DVB and DM&S field and VACO staffs met to discuss solutions to the timeliness problems encountered in completing compensation and pension examinations. It should be noted that problems were identified in both DM&S and DVB that needed to be addressed.

Both DVB and Medical Administration Service believe that, with the DM&S and - DVB Data Exchange project, many of the time delays encountered in forwarding C&P exam requests to VAMC's and returning completed examinations to VARO's will be solved. This project will completely eliminate the need for the paper C&P request form. Much time is lost in mailing exams between the VAMC and the VARO. Sometimes, a week in each direction is needed to get the request to proper elements for processing. It is anticipated that the electronic transmission of C&P requests from the VARO's to VAMC's will be in place in the fourth quarter of FY 89.

In the interim, DM&S has changed its policies to speed up examination processing. We have directed our facilities not to do specialty examinations unless one has been requested by the VARO. This may seem like a trivial point, but one of the biggest problems in completing these examinations is that many of our specialists feel that they cannot describe conditions which are outside their specialty. For example, one C&P request came into a VAMC for a general physical examination. The reviewing physician ordered eight specialty exams. This particular veteran had diabetes and was sent to the ophthalmologist to describe his eye grounds as one of his eight clinic appointments. DVB repeatedly requests that DM&S do only general physical examinations unless they stipulate that a specialty exam needs to be done, but DM&S has, in the past, continued to order more exams than are necessary from DVB's point of view. We continued to stress this issue in 10B and 13 conference calls.

Secondly, many of our active teaching facilities think that performing C&P exams does not enhance the teaching process, since residents performing exams are frequently unable to provide follow-up treatment for conditions they find on physical examination. This fact cannot be changed, but it is a disincentive for enthusiastic support of the program.

We have changed M-1, Part I, Chapter 20, to reflect the need to do only general exams unless otherwise requested. We have also provided VAMC's with flexibility to have exams completed on a fee basis, both in and outside of VA facilities. These policy enhancements were signed by the Chief Medical Director on January 26, 1988, and have been distributed to the field.

In addition, on or about July 1, 1988, the C&P distribution will be changed from the current method of mailing the requests to the COJ's to mailing the requests to the VA health care facility that has jurisdiction for the zip code of the veteran. This will reduce the time lost in mailing exams between facilities.

The Deputy CMD for Field Operations, Ray Avent, and Dr. Winship have met concerning co-location of Regional Offices with Medical Centers. In those places where co-location will occur, the time it takes to send completed exams back to the Regional Offices will be greatly reduced.

MAS provides 10B with a monthly C&P timeliness report. 10B has stressed the importance of this program over the weekly 10B conference call and in meetings with the Deputy Regional Directors.

Medical Administration (136F)
9 May 1988

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
C&P EXAMINATION UPDATE

Since our last update, DM&S Circular 10-88-55 dated May 23, 1988, has been signed off and published. This Circular advises all field facilities that effective July 1, 1988, referral of C&P examination requests, VA Form 21-2507, from VA regional offices will be sent directly to the VA health care facility in whose Primary Service Area the veteran resides. Requests will no longer be referred to Clinic of Jurisdictions for distribution and control.

Change to M-1, Part 1, Chapter 20, to correct language within the body of Chapter 20 to indicate that VA Form 21-2507 will be referred directly to that VA health care facility within whose Primary Service Area the veteran resides, has been drafted and is currently in the concurrence stage.

June 1, 1988

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE & SURGERY
C&P EXAMINATION UPDATE

Since our last update, the direct referral of C&P examination requests, VA Form 21-2507, from VA regional offices directly to that VA health care facility in whose Primary Service Area the veteran resides has been implemented (7-1-88). A few calls have been received for clarification purposes, however, no calls have been received indicating problems or inability to implement the new procedure.

Change to M-1, Part 1, Chapter 20, reflecting changes concerning the direct referral of VA Form 21-2507, has been through all concurrence points and is currently in 101B2 for their review and publication.

July 5, 1988

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE & SURGERY
C&P EXAMINATION UPDATE

The implementation of direct referral of VA Form 21-2507 from regional offices directly to that VA health care facility in whose primary service area the veteran resides has been in place for one (1) month. To date very few contacts have been received indicating problems or concerns with this new procedure.

Change to M-1, Part 1, Chapter 20, which reflects the requirement that VA Form 21-2507 will be forwarded to that facility in which the claimant resides, is in 101B2 for review and publication.

No other changes occurred during July.

August 1, 1988

Department of Veterans Benefits
Veterans Administration
Washington, DC 20420

DVB Circular 21-86-10

September 4, 1986

POST TRAUMATIC STRESS DISORDER

1. The purpose of this circular is to provide guidance in rating claims for PTSD (post traumatic stress disorder).

2. The issue of service connection is the sole responsibility of the rating board at the local level. In making that decision, it is important that the examining psychiatrist present a clear diagnosis showing a detailed history of the stressful events which are thought to have caused the condition and a full description of past and present symptoms. Because of the complexity of PTSD, the application of careful clinical judgment is necessary to identify and describe the relationship between past events and current symptoms. Service connection for PTSD will not be established on the basis of a diagnosis of PTSD unsupported by the above history and description or where the examination and supporting material fail to indicate a link between current symptoms and an inservice stressful event(s).

3. In determining whether PTSD is service connected, rating boards will consider the following factors:

a. The inservice traumatic stressor(s) must be adequately described by the examining VA psychiatrist. In addition, the examining psychiatrist should comment on the presence or absence of other traumatic events and their relevance to current symptoms. Relevant specific information concerning what happened must be described along with as much detailed information as the veteran can provide to the examiner as to the location in time (year, month, day), geographical location (corps, province, town, or other landmark feature such as a river or mountain), and the names of others who may have been involved in the incident. Examinations that are inadequate should be returned to the VAMC for reexamination.

b. Any evidence available from the service department verifying that the veteran served in the area in which the stressful event is alleged to have occurred (as described in subparagraph a above) and any evidence supporting the description of the event should be made part of the record. When the claimed stressor is related to combat, evidence of receipt of the Purple Heart, Combat Infantryman Badge, Bronze Star, and other similar citations are considered supportive evidence indicating possible involvement in a stressful episode. Other supportive evidence includes, but is not limited to, plane crash, ship sinking, explosion, duty on a burn ward or in a graves registration unit, and similar assignments. POW status is conclusive evidence of an inservice stressor.

4. When a claim for PTSD is received the following development will be undertaken:

LOCAL REPRODUCTION AUTHORIZED

a. Request all service medical records if not previously obtained.

b. The remarks section of VA Form 21-2507, Request for Physical Examination, will state "Claims folder to be made available to examiner upon request."

c. When the veteran indicates pertinent treatment in a VA facility or elsewhere, request for hospital report(s) and clinical records will be made. If Vet Center participation is indicated, the Vet Center records will also be requested.

d. In cases where records available to the rating board do not provide objective or supportive evidence of the alleged inservice traumatic stressor, it will be necessary to develop such evidence. While inservice traumatic stressors do not have to be documented to an absolute certainty, the supportive evidence of record must be sufficient to permit a rating board to reasonably conclude that the stressful event occurred as alleged. When necessary, development of such evidence will be accomplished as follows:

(1) The veteran will be requested to furnish specific details of the inservice stressful incident(s) such as date(s), place(s), unit of assignment at the time of the event(s), description of the event(s), medal(s) or citation(s) received as a result of the event(s), and if appropriate, name(s) and other identifying information concerning any other individuals involved in the event(s). The veteran should also be informed that the information is necessary to obtain supportive evidence of the stressful event(s) and that failure to respond may make it difficult or impossible to obtain such evidence.

(2) At the same time, the service department should be requested to furnish copies of appropriate pages from the veteran's personnel file showing unit assignments, dates of assignments, participation in combat operations, wounds received in action, awards and decorations, and official travel outside of the Continental United States.

(3) When the requested information from both the veteran and the service department is received, a letter should be sent to the U.S. Army and Joint Services Environmental Support Group, DAAG-ESG, 1730 K. Street, N.W., Room 210, Washington, DC 20006, requesting supporting evidence. Copies of information received from the veteran and the service department are to be enclosed with such requests. A VA examination which adequately describes the alleged stressors may be paraphrased as to the alleged stressors and enclosed to the Environmental Support Group if veteran does not respond to the request for details of the stressors.

5. In making a decision, the rating board will exercise fair, impartial, and reasonable judgment in determining whether a specific case of PTSD is service connected. Some relevant considerations are discussed below:

a. PTSD can be caused by events which occur before, during or after service. The relationship between stressors during military service and current problems/symptoms will govern the question of service connection. Symptoms must have a clear relationship to the military stressor as described in the medical reports.

b. PTSD can occur hours, months, or years after a military stressor. Despite this long latent period, service-connected PTSD may be recognizable by a relevant association between the stressor and the current presentation of symptoms. This association between stressor and symptoms must be specifically addressed in the VA examination report and to a practical extent supported by documentation as expressed in paragraphs 3a and b, and when applicable 4d.

6. Although it is expected that most PTSD claims will be resolved at the local level, Central Office opinion or guidance may be requested on complex cases. Cases or inquiries should be directed to the Chief, Regulations Staff (211B). The telephone number is FTS 389-3005.

7. RESCISSION: DVB Circular 21-82-7 and change 1.

R. J. VOGEL
Chief Benefits Director

Distribution: CO: RPC 2901
SS (211B) FLD: DVBFS, 1 each (Reproduce and distribute based on RPC 2068)

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

Circular 10-87-52

June 5, 1987

To: Regional Directors; Medical District Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics (Veterans Outreach Centers)

SUBJ: Post-traumatic Stress Disorder (PTSD)

1. PURPOSE: This circular is to provide guidance to DM&S physicians in making the diagnosis of PTSD and in reporting that diagnosis in a manner that is understandable and acceptable to rating boards of the Department of Veterans Benefits.

2. POLICY: The clinical diagnosis of PTSD will be based upon the results of clinical interview, review of claims file and military records and when indicated, specific psychological testing. Documentation of the diagnosis and its relationship to military service will be in sufficient detail to facilitate the adjudication of disability benefit claims as well as the formulation of treatment.

3. ACTION: This Circular is to provide specific guidelines for establishing the diagnosis of PTSD.

4. REFERENCES: DVB Circular 21-86-10.

5. RESCISSIONS: This DM&S Circular will expire on June 3, 1988.

6. FOLLOWUP RESPONSIBILITY: Director, Mental Health and Behavioral Sciences Service (116).

John A Gronvall, M.D.
JOHN A. GRONVALL, M.D.
Chief Medical Director

Attachment

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ATTACHMENT A

CIRCULAR 10-87-52
June 5, 1987

1. GENERAL:

a. The issue of service-connection is the sole responsibility of the rating board. The physician's responsibility is to present the clinical findings in a way that clearly demonstrates why the diagnosis of PTSD was made and, when applicable, why some other diagnosis was not made. Clinical findings which bear upon any relationship between military service and the diagnosis must be described. This diagnostic clarity should also be present when the patient is found to have some diagnosis other than PTSD.

b. The diagnostic evaluation for PTSD includes review of the patient's C-file, a clinical interview and mental status exam designed to determine the presence or absence of diagnostic symptomatology and precipitants and, when indicated, psychological testing. Recent research has validated several instruments that may aid in diagnosing PTSD. These include: The PTSD subscale of the MMPI, the Mississippi Scale for Combat Related PTSD, the PTSD Rating Scale and the Psychophysiological Assessment. (See reference list.) These instruments do not substitute for a clinical diagnostic interview.

It is important to realize that the interview to establish a diagnosis, particularly for compensation, may be a stressful experience for the veteran. This may be especially true for the veterans with PTSD, for whom issues of trust and feelings of alienation are often prominent. In addition, the veteran may be reluctant to experience the pain of relating fearful and threatening memories (e.g. of combat). For these reasons, it is vital that the interview be conducted in a sympathetic and understanding manner. This also makes even more important a thorough review of the C-file and military records to provide information the veteran may not mention or to provide clues about areas or situations the examiner may wish to explore on interview.

c. The diagnosis of PTSD must be consistent with the criteria of the psychiatric diagnostic system approved by the Veterans Administration: the current edition of the American Psychiatric Association, Diagnostic and Statistical Manual, the DSM-III-R. All criteria required for making the diagnosis must be met in order for a diagnosis of PTSD to be acceptable. To justify the clinical diagnosis, the following findings should appear in the clinical report presented by the examiner.

(1). That the veteran has experienced an event (stressor) that is outside the range of usual human experience and that would be markedly disturbing to almost anyone. Examples of such a stressor include: a life-threatening experience during combat, or a natural disaster or an accident, serious threat or harm to friends, rape or assault, or seeing other persons who have recently been or are being seriously injured or killed by accident or physical violence. Duty on a burn ward or combat medical (MASH) unit or on a graves registration unit may constitute such an experience. For purposes of establishing service connection, the stressor must have occurred while the individual was on active military duty. POW status is considered conclusive evidence of an inservice stressor.

(2) Reexperiencing the traumatic event either by recurrent . intrusive, distressing recollections or dreams, suddenly acting or feeling as if the event were recurring (including hallucinations, illusions, dissociative "flashback episodes") or psychological distress when exposed to events or situations that symbolize or resemble an aspect of the trauma (e.g. anniversaries).

(3) Persistent avoidance of stimuli associated with the trauma or a numbing of general responsiveness. This may include avoidance of thoughts, feelings, activities or situations that arouse recollections of the trauma; inability to recall aspects of the trauma, diminished interest in activities, feeling of detachment or restricted range of affect or a sense of foreshortened future.

(4) At least two of the following symptoms of persistent increased arousal not present before the trauma:

(a) difficulty falling or staying asleep
(b) irritability or angry outbursts
(c) difficulty concentrating
(d) hypervigilance
(e) exaggerated startle response
(f) physiological reactivity on exposure to events symbolizing or resembling aspects of the trauma

(5) Duration of the symptoms of 2,3, and 4 of at least one month.

Specific aspects of the differential diagnosis of PTSD from other disorders, including Personality Disorders, Substance Abuse, Depression and Schizophrenia, are well described in the Physicians Guide for Disability Evaluation Examinations (see Reference List). It is possible for PTSD to co-exist with other psychiatric disorders from Axis I and Axis II (e.g. Major Depression, Substance Abuse). In some instances the other disorder may be secondary to or associated with PTSD, while in other cases, the two disorders may be unrelated co-morbidities. The nature of the relationsip of PTSD to the other disorder(s) should be clearly stated.

d. The Evaluation Report must include the following elements:

(1) Clear and complete documentation of the diagnostic criteria that have been met to make the PTSD diagnosis. The development of symptoms since the traumatic event and the absence of these symptoms prior to the event must be noted.

(2) Clear and concretely detailed description of the stressor(s) including description of the event, location in time (as best it can be recalled: year, month, season, day if possible), geographic location (military unit, providence, town, landmarks such as river or mountain), and, if possible, names of others who may have been involved in the

incident. The claims file and military records as well as information from the veteran may be sources of this information. Often there are multiple stressors. The foregoing detail should be provided for at least one event, and descriptions of others should be provided to convey the cumulative nature of the stressful experiences.

(3) Clear and specific demonstration of the linkage between the symptoms used to make the diagnosis and the inservice stressful event. (e.g. content of intrusive recollection or re-experiencing of the inservice stressor which are similar to the actual stressors experienced. Such recollections should be of inservice stressors rather than recollection of other stressors from before or after service).

(4) Detailed description of the manner and degree to which the symptoms affect the necessary functioning of the veteran, including the effects upon personal relationship with family members, friends and others in social, religious, work and recreational activities (if any); upon productive activity, especially employment in obtaining and maintaining effective participation and upon the utilization of health services.

It is essential that physician examiners recognize that the value of their examination of the patient for rating purposes depends specifically on their ability to fulfill the requirements of items d (1), (2), (3), and (4). Rating boards have the authority and the responsibility to return as "inadequate for rating purposes" examination reports that do not satisfy these requirements. Accurate diagnosis is a primary clinical responsibility that has a major impact on the quality of care provided veterans within and outside the VA medical care system.

ATTACHMENT B

CIRCULAR 10-87-52
June 5, 1987

REFERENCE LIST

1. Keane, Malloy and Fairbank, "Empirical Development of an MMPI Subscale for the Assessment of Combat-Related Post-traumatic Stress Disorders", Journal of Consulting and Clinical Psychology, Vol. 52, pp 888-891, 1984.

2. Friedman, Schneiderman, West & Corson, "Measurement of Combat Exposure, Post-traumatic Stress Disorder and Life Stress Among Vietnam Combat Veterans", American Journal of Psychiatry, Vol. 143, pp 537-539, 1986.

3. Mallow, Fairbank & Keane, "Validation of a Multimethod Assessment of Post-traumatic Stress Disorder in Vietnam Veterans", Journal of Consulting and Clinical Psychology, Vol. 51, pp 488-494, 1983.

4. Keane, Caddell & Taylor, "The Mississippi Scale for Combat-Related PTSD: Studies in Reliability and Validity", available from Dr. T.M. Keane, Chief, Psychology Service (116B), VA Medical Center, Boston, MA 02130.

5. "Psychiatric Sequelae of Military Duty in a War Zone", Physicians Guide for Disability Evaluation Examinations, IB 11-56, Chapter 20, Veterans Administration, Department of Medicine and Surgery, March 1985.

6. Arnold, A., "Diagnosis of Post-traumatic Stress Disorder in Vietnam Veterans" in Sonnenberg, Blank and Talbott, The Trauma of War, American Psychiatric Association, Washington, D.C., 1985.

7. Arnold, A., "Selected Bibliography III: Post-traumatic Stress Disorder with Special Attention to Vietnam Veterans", Veterans Administration, Southeast RMEC, Birmingham, AL, December, 1986.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

AUG 8 1988

Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans Administration on section 601 of S. 2011, 100th Congress. That provision would add a new subsection to 38 U.S.C. § 602, directing VA to furnish priority care to all Vietnam theater veterans who seek care for service related post-traumatic stress disorder (PTSD). To receive this priority, the Chief Medical Director must make a diagnosis of PTSD and determine that it is related to Vietnam service. However, proposed Committee Report language will express a Congressional intent that the Chief Medical Director should delegate this authority to "the local level." The Report will also state that to show service in the Vietnam theater, the veteran may simply present a Form DD-214 showing receipt of the Vietnam Service Medal. The measure would require VA to furnish care for PTSD on a priority basis as if the disorder had been formally adjudicated as service-connected, even though a formal adjudication of service-connection would not be required. VA opposes the measure.

VA has the greatest compassion for those who served in Vietnam and are now suffering from PTSD as a result of that service. In the few years since PTSD has become a widely recognized disorder, the agency has significantly expanded the availability of care to those who are suffering from it. Various witnesses at the recent Senate oversight hearing on PTSD detailed the wide array of PTSD treatment modalities available in the VA system. VA will continue in its efforts to expand programs for PTSD, and to provide all necessary care for that disorder. One of the reasons for opposing this measure is that it would be the first instance of a priority for care being given on the basis of a particular diagnosis. If PTSD treatment needs a greater priority in the VA, the agency should have the opportunity, as we testified at the recent hearing, to devise ways of providing this priority within the total health care system operated by VA, without such a legislative constraint.

We understand that the recently released preliminary results of the National Vietnam Veterans Readjustment Study being conducted by the Research Triangle Institute (RTI) gave impetus to this proposal. It would be precipitous, however, to enact legislation based upon those early findings. The final report of the RTI study will not be forthcoming until November of this year. In our view, that final report should be received, and its findings should be thoroughly reviewed and analyzed by the Chief Medical Director's Special Committee on PTSD, before legislation is enacted. The Chief Medical Director testified at the recent hearing that the Agency's future PTSD activities would be planned only after a thorough review and analysis of the RTI Readjustment study's findings and conclusions.

Finally, we object to section 601 of S. 2011 because it would treat veterans as service-connected when they have not been formally adjudicated service-connected. Under the measure, all that is needed is that the diagnostician determine that PTSD is service-related, and that the veteran produce evidence of Vietnam service, such as a DD-214 showing receipt of the Vietnam Service Medal. We are somewhat concerned about the confusion which could result from veterans learning that VA will treat them for PTSD, but that they may not be eligible for compensation for the disorder. We recognize that this situation may seem to be similar to the special priority given to agent orange and ionizing radiation. Veterans can receive priority care for disorders which may be related to exposure to agent orange, or to ionizing radiation, despite the fact that the disorder might not be formally adjudicated service-connected, and the veteran might not receive compensation. However, PTSD differs from these disorders in that PTSD is a disability that is an integral part of the compensation rating schedule. Therefore, veterans whose PTSD is related to their service in Vietnam may be granted compensation through the normal adjudication process.

We estimate the costs of enactment of section 601 of S. 2011 would be approximately $13.9 million in fiscal year 1989 and $69.5 million over the next five fiscal years.

The Office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on S. 2011 to the Congress.

Sincerely,

THOMAS K. TURNAGE
Administrator

Cost Methodology

The following is an estimation of increased costs required to meet the anticipated increased workload that would result from the passage of this legislation. Assumptions and costing methodology are provided.

a. Readjustment Counseling Service estimates that the Vet Centers currently refer 39,000 veterans with PTSD to VA medical centers each year. We assume that this number will not increase with the proposed legislation.

- 2/3 of these are estimated to go to MHC's - 26,000
- 100% of these are briefly evaluated
- only 20% are estimated to become engaged in treatment.
- if veterans with PTSD are given the priority for treatment proposed by the legislation, another 50% could be expected to seek out and become engaged in treatment = 13,000 patients
- each would require an average of 10 visits/year
- cost per visit to MHC (9/87) is $46.51
- therefore: 13,000 x 10 x $46.51 = $6,046,300

b. We currently treat 10,000 veterans with PTSD on our general psychiatric inpatient units and our specialized PTSD inpatient units. PTF data indicates that 36% of veterans treated for PTSD were service-connected for PTSD and another 30% of the veterans treated for PTSD were service-connected for another condition. Of the remaining 34% who are not service-connected and are receiving treatment for PTSD, 80% would benefit from outpatient care and would be likely to be referred to these programs because of the legislation.

- 3,400 NSC patients x 80% x 10 visits x $46.51 = $1,265,072
- Minus savings from not receiving inpatient care

c. 466 veterans are currently waiting for treatment in specialized PTSD programs, and we would anticipate more veterans seeking care if the legislation were passed (one percent of current referrals from Readjustment Counseling Service). However, our experience suggests that providing funds to establish additional specialized programs is not the most therapeutically advisable or cost effective approach to patients. To meet these increased patient care demands we recommend:

- directing available funds in each region to enhance the treatment capabilities of one specialized PTSD unit so that it would be capable of serving as a regional treatment program and could absorb many of the patients requiring these intense treatment services: $300,000 x 7 = $2,100,00

- add 30 treatment teams at selected medical centers to improve local treatment capabilities and thus reduce the number of referrals made to the specialized progams.

- 2 FTEE per PTSD treatment team (one physician and one GS-12/5 clinician) = $150,000
- $150,000 x 30 PTSD treatment teams = $4,500,000

Total cost: $13,911,372

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
July 14, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies Auxiliary, I deeply appreciate this opportunity to appear here today to present our views on the Veterans Administration's efforts concerning Post Traumatic Stress Disorder (PTSD) and the broad range of issues related thereto.

Mr. Chairman, it has been a little over 15 years since the evacuation of Saigon which signaled our nation's end of official activities in the Republic of Vietnam. Some 13 years have lapsed since the end of the Vietnam era was proclaimed by then President Gerald R. Ford -- May 7, 1975.

However, the debate of the nature and extent of our involvement in Vietnam has been an oft debated issue from nearly all quarters of the country. Perhaps the most commonly mentioned and troublesome area of such debate centers on the problems and challenges faced by Vietnam era veterans in readjusting to civilian life.

Mr. Chairman, the DAV has continually expressed its commitment and concern toward assisting Vietnam era veterans suffering psychological problems associated with their military service in Vietnam. It was the DAV that provided funds for "The Forgotten Warrior Project," which lead in October 1978, to the DAV initiating our own Vietnam Veterans Outreach Program. The result of this study had a direct influence on not only our organization's establishment of a specific counseling program for Vietnam veterans but, we feel, on the decision of Congress to provide the necessary funds which authorized the Veterans Administration to create "Operation Outreach" and subsequently establishing the current network of Vet Centers (Public Law 96-22).

Mr. Chairman, in 1983 Congress directed the VA (Public Law 98-160) to conduct a comprehensive study of the prevalence and incidence in the population of Vietnam veterans of Post Traumatic Stress Disorder (PTSD) and other psychological problems in readjusting to civilian life. In September 1984, the VA awarded a contract to the Research Triangle Institute (RTI) to conduct the mandated study, which has become known as the National Vietnam Veterans Readjustment Study (NVVRS). Although the completion of this study will not occur for sometime -- estimated to be October 1988 -- preliminary findings from one major component -- the National Survey of the Vietnam Generation (NSVG) -- are available.

Mr. Chairman, we have recently received a copy of the first replicate report of the National Vietnam Veterans Readjustment Study. Our views on the findings of the data are based on a preliminary review only and may not be complete pending our more detailed review.

The NVVRS has three broad goals:

1. To provide information about the incidence, prevalence and effects of PTSD and related postwar psychological problems among Vietnam veterans;

2. To provide a comprehensive description of the overall adjustment of Vietnam theater veterans compared to era veterans; and

3. To provide detailed scientific information about one specific type of postwar psychological problem: PTSD.

Mr. Chairman, This report must be considered as preliminary in several ways in that:

* It presents findings based on survey interviews with a random 1/3 subset of the total National Survey of Vietnam Generation (NSVG) -- a total of 610 veterans interviewed;

* It is purely descriptive;

* It presents findings only from NSVG interviews and not from other components of the NVVRS;

* It describes the occurrence of psychiatric symptoms rather than the prevalence rates for specific psychiatric disorders; and

* It presents estimates for Vietnam theater and era veterans, but not their civilian counterparts.

Mr. Chairman, the data contained in this advance report reveals:

* The sample of veterans examined in the NSVG was broader and more inclusive than those of past studies. As a result, the descriptions of Vietnam theater and era veterans found in the report are in some ways different from, but more representative than, descriptions reported in previous research;

* The majority of Vietnam theater veterans have made a successful re-entry to civilian life and have experienced few symptoms of Post Traumatic Stress Disorder (PTSD) or other readjustment problems;

* Although, in general, male theater veterans do not differ greatly in life adjustment from their era veteran

counterparts, there is some evidence that female theater veterans have experienced higher levels of readjustment problems than era veteran women of similar age and military occupation;

* Among the substantial minority of Vietnam theater veterans who have experienced past or current readjustment problems, some important findings have emerged. These include;

-- The prevalence of PTSD symptoms and other postwar psychological problems is significantly higher among those with higher levels of exposure to war zone stressers. This suggests a prominent role for exposure to war stress in the development of subsequent psychological problems, and confirms that those who were most heavily involved in the war are those for whom readjustment was, or continues to be, most difficult.

-- Black male theater veterans typically report more PTSD symptoms and other readjustment problems than white/other or Hispanic males. Preliminary analysis of those differences suggest that they are not due to a general propensity for blacks to report more symptoms and are not adequately accounted for by certain other factors, such as exposure to war zone stress, education, composition of family of origin, etc. Higher proportions of black male theater veterans were also found to have sought professional mental health care.

-- There is generally a strong relationship between PTSD symptoms and other postwar readjustment problems, in that having higher numbers of PTSD symptoms increases the likelihood of having a wide variety of other that having higher numbers of PTSD symptoms increases the likelihood of having a wide variety of other problems. The net effect of this relationship is to concentrate readjustment problems among that subset of Vietnam veterans who have experienced higher numbers of PTSD symptoms.

-- While many Vietnam veterans have received mental health care from a variety of sources since leaving the military (including VA Medical Centers and Veterans Outreach Centers), a substantial proportion of those with high current PTSD symptomatology had not seen a mental health professional in the past year (i.e., they are not currently being treated). This may represent a substantial unmet need for treatment.

Clearly, Mr. Chairman, this preliminary data tends to portray "good news" for Vietnam theater veterans in that the majority have made a successful re-entry to civilian life and have experienced few symptoms of PTSD or other readjustment problems and; theater veterans do not differ greatly from their Vietnam era counterparts.

Just as clear, is the fact that a substantial number of Vietnam theater veterans have experienced past or current readjustment problems. We find it alarming that the prevalence of PTSD symptoms are found to be significantly higher among veterans with higher levels of exposure to war zone stressers, black male theater veterans and female theater veterans.

Mr. Chairman, we look forward to reviewing the completed NVVRS as we feel it will provide the most comprehensive set of data yet available relating to Vietnam veterans and will act as the cornerstone for better understanding the various symptomatology and readjustment problems encountered by Vietnam veterans.

Another major component of the VA's effort in addressing the complex issues surrounding PTSD was the creation of the Chief Medical Director's Special Committee on Post Traumatic Stress Disorder.

Mr. Chairman, Public Law 98--528 mandated the Special Committee to assess the capacity of the VA to provide diagnostic and treatment services for PTSD for all eligible veterans. The Special Committee is also charged to advise the Chief Medical Director regarding the development of policies, provision of guidance and the coordination of services for the diagnosis and treatment of PTSD in various treatment settings. The Special Committee, via its first four annual reports, has considered the issue of PTSD diligently and offered recommendations concerning a vast array of divergent issues relating to PTSD.

In our view, Mr. Chairman, the last three plus years have been witness to an extraordinary effort being forged by a select group of dedicated professionals committed to ensuring that veterans receive the most complete, efficient and quality services possible in conjunction with PTSD. The DAV is appreciative and applauds the efforts advanced by the Special Committee thus far.

Since the Special Committee's first annual report -- December 1985 -- a variety of recommendations spanning virtually all aspects of the PTSD issue have been formulated and put forth to the Chief Medical Director for consideration.

Mr. Chairman, we are pleased to note that a substantial number of these recommendations have been favorably responded to and concurred in by the Chief Medical Director. Also, many more are apparently in the process of being considered or implemented.

Unfortunately, the Special Committee has repeatedly forwarded a number of recommendations crucial to the PTSD issue that have been dismissed, minimized, or not fully implemented by the Chief Medical Director and/or Chief Benefits Director.

These include:

* The Special Committee's concern that the Diagnosis Related Group (DRG) reimbursement formula is inequitable and constitutes a disincentive to the establishment of specialized PTSD treatment modalities;

* Educational programs for DVB adjudicaters, to include the Board of Veterans Appeals, with cross training involving the Department of Medicine and Surgery staff to focus specifically on the process of adjudicating PTSD claims, designed to narrow the wide disparity between Regional Offices regarding the rate of approval and percentage of disability assigned;

* Concern that some of the existing 15 PTSD treatment teams are making uneven progress toward establishing an effective treatment team that results in veterans being deprived of appropriate and needed treatment.

Mr. Chairman, in addition to the recommendations noted above stemming from the Special Committee's concern in those areas, the DAV has certain concerns we believe must be addressed by the VA in the near term.

While the VA has conducted -- and apparently plans to continue -- training for VA health care providers, we believe a necessary augmentation is to include certain non-VA health care providers in the VA's training endeavors.

We are concerned, Mr. Chairman, that certain veterans that reside geographically distant from a VA health care facility may not be able to receive appropriate treatment for PTSD from available community mental health providers. This situation effectively precludes certain entitled veterans from receiving the care they require. This concern becomes even more evident and crucial when considering the VA, by and large, possess the singular source of expertise and capability in the training and educational areas for PTSD in the country.

Entwined in the above is the need for adequate funds to effectively maintain a contract treatment program for providing needed care for PTSD symptoms. It is unrealistic to presuppose the VA will be capable of meeting the entire demand for these services. Thus, contract care in the community becomes, for the most part, the only feasible alternative. We are extremely concerned with the steady decline of the contract care program. If such a decline continues at the current pace we fear significant numbers of veterans will be deprived of access to needed care with potentially devastating results.

Mr. Chairman, another dimension of care -- which reverts back to the issue of training and education -- is not only the VA's ability to provide adequate and an appropriate degree of care for veterans afflicted with PTSD, via the various treatment approaches available, but, also, the ability to ensure that allied health professionals in other clinical settings have a basic awareness of PTSD symptomatology that promotes recognition of the condition.

Mr. Chairman, we continue to be concerned with the effectiveness and ability of the Center for Stress Recovery (CSR) -- located at the Brecksville, Ohio VA Medical Center -- to carry out its functions as a National Center for PTSD as mandated by Public Law 98-528. The CSR is to act as a National Center for treatment, education and research. It is our understanding that numerous questions have surfaced regarding the effectiveness of the CSR and we urge the VA to address and resolve this issue in an expeditious manner.

Mr. Chairman, we continue to view the Vet Centers as fulfilling a meaningful role in the delivery of readjustment services to veterans. However, we continue to feel it imperative that the Vet Centers and parent Medical Centers develop a harmonious and meaningful relationship that permits appropriate referrals for needed medical care and other services.

It is our belief that until such relationships occur, on an ongoing basis, veterans will not receive the continuum of care they require and are entitled to.

Mr. Chairman, one final area of concern that we feel needs to be addressed relates to research of PTSD, particularly as it relates to direct patient care and the various modalities of care available. We urge the VA to consider PTSD as a priority research area as it is, in fact, a direct resultant disability of combat. Efforts should be made to solicit appropriate research projects and subject the protocols to rigid merit review by a body of individuals possessing sufficient expertise in the field. Also, full funding of approved protocols should be the norm.

The remaining issue we wish to address concerns the VA's adjudicative process of PTSD claims.

We are aware, Mr. Chairman, that information exists suggesting some Regional Offices grant service-connected status for veterans claiming PTSD on a relatively low proportionate basis when compared to the number of veterans being diagnosed as suffering from PTSD by contingent VA medical facilities. Certain variables may be identified to control for some of these cases while no reasonable explanations exist for others. In this regard, we support and urge the continuous education and training of DVB adjudicative personnel, via cross training with DM&S staff, as previously discussed. Certainly, this approach will enable DVB personnel to be aware of what is available and necessary to render a definitive diagnosis of PTSD.

Also, sequential development of claims must occur that ensures the veteran's statement concerning the stressor, as well as any supporting documentary evidence, be a part of the record prior to an examination for compensation purposes.

Additional concerns highlighted by the Special Committee include:

* Inaccurate, inadequate or conflicting medical information received by Rating Boards to serve as the basis for adjudication of claims; and

* Use of non-VA contract physicians who have little or no expertise or experience in treating and diagnosing PTSD.

Mr. Chairman, overall we are generally satisfied with the VA's adjudication of PTSD claims. Since June 1, 1985, when the VA initiated a data base on these claims, through May 24, 1988, 29,171 disability cases have been received by the VA from veterans. Of that total, 15,957 cases (54.7%) have been favorably acted on at the Regional Office level.

Additionally, in Fiscal Year 1987, the Board of Veterans Appeals rendered 1,224 appellate decisions (541 cases -- 44.2% -- represented by the DAV) of cases involving PTSD). Of that total, 183 cases (15.0%) (108 cases -- 20.0% -- represented by the DAV) received favorable decisions and an additional 453 cases (37.0%) (192 cases -- 35.5% -- represented by the DAV) were remanded to Regional Offices for additional development. Of that number, 116 veterans (25.6%) (67 cases -- 34.9% represented by the DAV) were granted benefits following completion of BVA's requested development. In our view, these statistics portray the VA as an agency that is not arbitrarily disallowing veterans' claims for benefits attributable to PTSD.

In conclusion, Mr. Chairman, our views may be best summarized by a statement contained in the Special Committee's second annual report dated February 1, 1986, wherein they state:

> ".... it was through no fault of their own that young men and women were asked to risk their lives in Vietnam. It was not their fault that national recognition of their valor and sacrifice was delayed until 1980. And it is not their fault that requests for long delayed treatment of their combat related PTSD should come at a time that the Nation is reluctant to undertake any new expenditures.
>
> PTSD can be a devastating problem. If untreated it often gets worse with time. If there really is a national commitment to provide treatment for combat veterans with PTSD, then there must be a national willingness to provide that treatment."

Mr. Chairman, that concludes my testimony and once again I want to thank you for allowing us the opportunity to appear here today.

Statement of

The American Legion

**1608 K STREET, N. W.
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by

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THE AMERICAN LEGION

and

JOHN F. SOMMER, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

on

POST TRAUMATIC STRESS DISORDER

JULY 14, 1988

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
JULY 14, 1988

Mr. Chairman and Members of the Committee:

The subject of Post-Traumatic Stress Disorder, and the manner in which it is approached by the Veterans Administration is an issue that is extremely important to The American Legion, and thus we appreciate the fact that you have scheduled today's hearing.

CMD'S SPECIAL COMMITTEE ON PTSD

At the outset, we feel it important to reiterate a statement included in our testimony of June 16, 1988, presented to this Committee, relating to the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder. In addressing a proposal to mandate the Committee to develop and submit a series of specific reports, which is supported by The American Legion, we stated that the Special Committee is carrying out a number of important responsibilities relating to the Veterans Administration's ability to diagnose and treat PTSD. One of the several reasons that this Committee is effective is that it does report to Congress on its findings and recommendations. The legislation that established the Special Committee and sets forth its responsibilities, PL 98-528, only mandated the presentation of annual reports to Congress through 1989. The American Legion feels very strongly about the importance of the work that is being carried out by the Special Committee, and again states its support for the provision contained in S. 2462.

Mr. Chairman, with respect to the annual reports of the Special Committee, we still do not understand why it takes the Veterans Administration approximately a year to submit these reports to the Congress. The Committee, as required by the law, has developed and submitted them to the agency in a timely manner early each year since 1985.

READJUSTMENT COUNSELING PROGRAM

The Vet Center program has become an integral part of the overall VA health care delivery system, enhancing continuity of care and greatly improving the understanding throughout the Veterans Administration of psychological readjustment needs of combat veterans.

The nationwide workload totals for the Readjustment Counseling program in Fiscal Year 1987 show the second highest level for new veteran clients, and the highest number of total visits since the inception of the program in FY 1980. Available figures show that last year 73,139 new veteran clients were seen, and there was a total of 142,965 veterans seen during 521,934 visits.

The American Legion was pleased with respect to the provisions of PL 100-322 relating to the Vet Center program that were enacted recently. The law repealed the mandatory transition of the Vet Centers from storefront operations into VA medical centers; requires the Administrator to submit an extensive national plan which sets forth plans with respect to each Vet Center in existence on February 1, 1988; and prohibits any action being taken with respect to any Vet Center for 120 days after submission to Congress of the national plan.

The American Legion has found that the Vet Center program is continuing to do well in accomplishing the purpose for which it was established - to provide readjustment counseling and referral services to those veterans who have not satisfactorily completed post-Vietnam recovery and readjustment processes. We see no reason why entitlement should not be extended to World War II and Korean Conflict veterans, and veterans who have served in hostilities after May 7, 1975, as we have mentioned to the Committee previously.

CDC VIETNAM EXPERIENCE STUDY

Following preliminary analysis of the findings of the Vietnam Experience Study, it appears that another study conducted by the Centers for Disease Control has been gravely flawed. The Vietnam Experience Study, the second of three studies that were to be carried out by CDC, was mandated by PL 97-72 as an expansion of the scope of the Agent Orange Study mandated by PL 96-151.

Section 401 of PL 97-72 states, in part, as follows: "In conducting such study, the Administrator may expand the scope of the study to include an evaluation of any long-term adverse health effects in humans of such service as such health effects may result from other factors involved in such service, including exposure to other herbicides, chemicals, medications or environmental hazards or conditions. The Administrator may also include in the study an evaluation of the means of detecting and treating adverse health effects found through the study."

Some of the major flaws are briefly highlighted below.

Dilution of Effects through Improper Exposure Definitions

The first flaw is that CDC has deliberately restricted itself to a vaguely defined generalized experience in Vietnam rather than focusing on the specific issues it was mandated to investigate, as set forth previously, which are the physical, chemical and psychological exposures of the Vietnam War.

By defining the "exposure" as a generalized "experience" in Vietnam, CDC has committed a classic flaw in epidemiological study design called the "dilution effect". That is, if the exposure is the general experience, then every person who served in Vietnam is defined, by design, to have been equally exposed to the chemical, physical or psychological hazard. Since approximately only 1 out of every 5 men who served in has diluted the study population through the inclusion of non-exposed veterans, and has decreased the statistical power of the study by eliminating those likely to have been exposed.

Biased Interpretation

In addition to a flawed basic design, CDC compounds its own error with an interpretive bias designed to obscure any results which indicate that a health or well-being problem exists among the veterans. In the analysis of the incidence of PTSD, CDC was forced to separate actual combatants from the other Vietnam-based troops. This is because the clinical definition of PTSD, as defined by the American Psychiatric Association's DSM III, requires a specific exposure to trauma.

When forced to stratify the study population, CDC found that the veterans who were exposed to the trauma of combat are indeed suffering from PTSD and other long-term psychological dysfunction. However, these findings are downplayed by CDC in the general conclusions as follows:

"These psychological problems, however, are not of a magnitude that has resulted in Vietnam veterans having as a group (emphasis added) lower social and economic attainment." This telling phrase is the key to recognizing the inherent bias in analyzing, interpreting and describing the results. It appears that the authors are intent on submerging or obscuring important effects by diluting the subgroups to which they pertain. In other words, in the body of the paper PTSD effects are found, but in the conclusion their importance is purposely downgraded.

There are also some other extremely important points that should be noted. It is our understanding that good research dictates that when an effect is found when the combat experience was taken into consideration, all previous findings should immediately be re-analyzed to see if they too may have been combat dependent. This was not done in

Vietnam was actually engaged in combat, any possible effects of the exposure will be diluted out when the "normal" experience of the 4 non-exposed men is averaged in. Let us say hypothetically that exposure to combat caused a doubling of the incidence of ulcers among the 20% exposed veterans, the effect would be obscured because 80% of the group being studied would not have been involved in combat and would have a normal background rate of the disease. Only extremely large increases in any disease rate could be discovered and reach statistical significance in a population so diluted.

The dilution effect caused by the inclusion of a majority of veterans with no exposure in the study population is compounded by the deliberate exclusion of some veterans who are likely to show health effects. By design, CDC eliminated veterans with multiple tours of duty in Vietnam, and anyone over the grade of E-5. Although this criteria is not as restrictive as that used in the Agent Orange study, in our opinion it is too restrictive, and damaging to the study.

It is extremely important to keep in mind that by and large, veterans in the 35-45 year old age group should be a healthy group of individuals. They were only admitted into the Armed Forces after passing rigorous physical and psychological examinations. Men in the 35-45 year old age group, as a whole, do not develop many diseases or disorders. Therefore, the prevalence of disease and disability in this group is expected to be low.

A knowledgeable epidemiologist, in our estimation, would try to optimize the chances of observing an effect by including, rather than excluding, the veterans who are most likely to have suffered from the exposures in question. This is one of the most simple applications of the concept of "statistical power", or the statistical ability to observe an effect if one is present.

CDC has thus committed two of the cardinal sins of epidemiology. The agency the Vietnam Experience Study, nor did CDC differentiate among different levels of combat.

From some of the earlier studies on Vietnam veterans, it has made good scientific sense to hypothesize that the effects of the war would vary, depending upon the levels of combat experienced by the participants. This was one of the major conclusions of the first Congressionally mandated study on Vietnam veterans entitled "Legacies of Vietnam". Research projects since that time, including The American Legion's own Vietnam veterans study, have repeatedly confirmed this conclusion. We are not aware of any other researchers who have dealt with the issues of the Vietnam War and health, who have not taken actual combat into consideration in the basic study design. We do not know whether this was done through a lack of knowledge or a deliberate attempt to limit the possible findings. Whatever the original intent, the end result is that some major findings are missed.

Faulty Interpretation: Calling Positive Effects Negative

Despite flaws in the study design, the CDC data still show positive findings. That is, the Vietnam "experience" did adversely affect the health and well being of some Vietnam veterans. However, each time CDC came up with a positive finding, it was then interpreted to be either negative or wrong.

One example is the PTSD finding mentioned previously. It was a positive and important result - the importance of which was minimized.

Another is that one of the basic assumptions in the design of the study is that veterans are unreliable sources of information about their own health or their past medical history. On this basis, CDC justified an extremely expensive, cumbersome and inefficient study based on personal health examinations of selected veterans. In the May 13 report, CDC compares the health status of veterans obtained from a telephone interview to the health status from a physical examination. Not only were these data statistically indistinguishable, but where differences occurred, the trend was that the veterans had underestimated, rather than overestimated, various indicators of poor health. CDC should have emphasized this as an important finding. Instead the differences were described as recall bias, which undermines some findings of the study.

In the report, on the Experience Study, the following "positive" findings were among those obtained in the case of those veterans who served in Vietnam:

a. Nearly double the rate of left ventricular hypertrophy

b. Greater hearing loss

c. Higher levels of GGT, thyroid stimulating hormone and glucose

d. Almost triple the rate of occult stool blood

e. Greater rate of evidence of past hepatitis B infection

f. Two of three sperm analyses significantly abnormal

g. One case of porphyria cutanea tarda, an extremely rare disease associated with herbicide exposure in the past.

None of these findings was discussed in any serious detail in the report. The abstract states that "few objective differences in physical health between the two groups" were found. This appears to be an attempt to minimize the findings.

With respect to another important area when abnormal skin conditions as a whole were investigated, there was a large and significant increase in the rate of these conditions among those veterans who served in Vietnam. However, CDC rather than considering this to be at least a highly suggestive, if not a definitive finding, proceeded to classify the skin conditions differently in a second table, which does not appear to be consistent with the first table, and thus turns a positive finding into a nebulous one. This is a particularly disturbing action since skin conditions should be considered, by objective researchers, as particularly important to evaluating toxic herbicide exposures.

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Unjustified Refusal to Use Available Exposure Data

Any study of the effects of environmental exposures is limited by the extent to which one can define and quantify the exposure. In general environmental studies of water and air pollution, one is often forced to extrapolate regional or even national exposures from a relatively small number of actual measurements. In occupational environments many researchers must simply substitute number of years in a particular job classification for an actual exposure measure.

In the case of herbicide exposures during the Vietnam War, there is an extraordinarily comprehensive and valuable data set available for quantifying exposures. The U.S. Army and Joint Services Environmental Support Group (ESG) has carefully reviewed virtually all troop movement during the Vietnam War and has reduced this to a codified computer file.

ESG has also developed a Services HERBS tape which contains available records on backpack spraying, helicopter sorties, perimeter spraying, and wheeled vehicle missions. It also contains records of aborts, dumps and leaks that occurred during Operation Ranch Hand spraying missions, plus additional Ranch Hand missions that are not contained in the original HERBS tapes.

The use of this information in determining exposure for both the Agent Orange study which was previously mentioned, and for the Vietnam Experience Study, is vitally important. Although CDC has unilaterally declared that these data are not useful, the agency has not presented sufficient evidence or a logical reason that convinces us that the information contained in the Services HERBS tapes and the HERBS tapes is not useful.

We would like to point out that computerized methods for using this data as an exposure classification system exist, have been published in the peer reviewed scientific literature, and are in use in our own study of Vietnam veterans, as well as in several other studies and applications. This is not to state that one can evaluate precisely the extent of every veteran's exposure to herbicides. Rather, we are emphasizing that such an index is extremely useful for classifying veterans into major exposure probability categories such as not likely to have been exposed, low, medium and high exposure. Such stratification, when available, is of the utmost importance in study design. The failure to utilize an existing system in the CDC studies is a fatal flaw.

In the Agent Orange study, CDC did make an attempt to define exposure to herbicides by using a system which can only be regarded as simplistic for exposure classification. The Exposure Opportunity Index uses only a subjective evaluation of the likelihood of having been exposed to herbicides, without using the computerized spraying records. While chosing this simplistic approach, CDC rejected one of the most carefully developed and extensive records of any environmental exposure to be found anywhere in epidemiologic research.

NATIONAL VIETNAM VETERANS READJUSTMENT STUDY

The American Legion has completed but a basic review of the preliminary findings of the National Vietnam Veterans Readjustment Study, as a copy of the report was received within the past few days.

The study results from the enactment of PL 98-160 which mandated the Veterans Administration to conduct a comprehensive study of the prevalence and incidence in the population of Vietnam veterans of PTSD and other psychological problems in readjusting to civilian life. A contract was awarded to Research Triangle Institute by the VA in September 1984, to conduct this study. An advance data report has been published to present preliminary findings from one of the major components of the study entitled the National Survey of the Vietnam Generation.

The introduction to the report states that it is preliminary in several ways. It presents findings based on interviews with a random one-third subset of the total study sample; it is purely descriptive, providing only tabulations of basic findings; it presents findings only from the survey interviews and not from other components of the study; it describes the occurrence of psychiatric symptoms rather than the prevalence rates for specific psychiatric disorders; and it presents estimates for Vietnam theater and era veterans, but not for civilian counterparts as will be presented in subsequent reports.

Some of the highlights of the findings, as set forth in the Executive Summary of the report are as follows:

# The majority of Vietnam theater veterans have made a successful reentry to civilian life and have experienced few symptoms of post-traumatic stress disorder or other readjustment problems.

# Although in general male theater veterans do not differ greatly in life adjustment from their era veteran counterparts, there is some evidence that female theater veterans have experienced higher levels of readjustment problems than have era veteran women of similar age and military occupation.

# Among the substantial minority of Vietnam theater veterans who have experienced past or current readjustment problems, some important findings have emerged, including:

1. The prevalence of PTSD symptoms and other postwar psychological problems is significantly higher among those with higher levels of exposure to war zone stressors. This suggests a prominent role for exposure to war stress in the development of subsequent psychological problems, and confirms that those who were most heavily involved in the war are those for whom readjustment was, or continues to be, most difficult.

2. Black male theater veterans typically report more PTSD symptoms and

other adjustment problems than white/other or Hispanic males. Preliminary analyses of these differences suggest that they are not due to a general propensity for blacks to report more symptoms and are not adequately accounted for by certain other factors, such as exposure to war zone stress, education, composition of family origin, etc. Higher proportions of black male theater veterans were also found to have sought professional mental health care.

3. There is generally a strong relationship between PTSD symptoms and other postwar readjustment problems, in that having higher numbers of PTSD symptoms increase the likelihood of having a wide variety of other problems. The net effect of this relationship is to concentrate readjustment problems among that subset of Vietnam veterans who have experienced higher numbers of PTSD symptoms.

4. While many Vietnam veterans have received mental health care from a variety of sources since leaving the military (including VA Medical Centers and Veterans Outreach Centers), a substantial portion of those with high current PTSD symptomatology have not seen a mental health professional in the past year (i.e., they are not currently being treated). This may represent a substantial unmet need for treatment.

Mr. Chairman, this is an important study, and will undoubtedly result in the provision of very pertinent data with respect to the readjustment of Vietnam veterans. The American Legion will certainly analyze the data contained in this preliminary report, and look forward to the release of the complete study findings.

The Columbia University and American Legion Vietnam Veterans Study

One of the five reports of findings that will be published from the Columbia University-American Legion Vietnam Veterans Study is titled "Post Traumatic Stress Disorder Among American Legionnaires in Relation to Combat Experience in Vietnam:

Associated and Contributing Factors".

Pre-publication data shows that the relationship between combat stress, DSM III-defined post-traumatic stress disorder, and a variety of behavioral factors was examined in a large nonclinical population. A total of 2,858 randomly selected American Legion members who had served in Southeast Asia completed a questionnaire which elicited information on military service, personal health and a variety of mental health outcomes. The data confirm the utility of the PTSD diagnosis as a distinct clinical entity. The frequency of PTSD and the extent of symptoms developed varied with the severity of criteria used for determining the extent of traumatic exposure. The PTSD rate ranged from 1.8 to 15% of the total sample, depending on whether "exposure" to combat was defined relatively narrowly or broadly. A distinct linear dose - response relationship between combat stress and a quantitative measure of PTSD intensity was observed. The frequency of PTSD diagnosis was not affected by the presence of either physical or mental health problems which predated military service. A strong, stable relationship was found between combat stress and PTSD intensity for cohorts with differing intervals since the experience of combat trauma, which persisted up to twenty years after discharge from the military. The data thus support a broader approach to defining traumatic events which recognizes individual differences in response to combat, as well as the existence of other behavioral outcomes as residual effects of combat. Implications of these findings and the importance of treating veterans with varying presentations of PTSD are discussed in the report which, as mentioned previously, is pending publication.

TREATMENT OF PTSD IN VA FACILITIES

Mr. Chairman, veterans suffering from post-traumatic stress disorder are provided treatment through a multitude of different programs, depending upon the VA facility from which the individual seeks treatment. It appears that in a majority of the medical centers veterans with PTSD are treated on general psychiatry wards. Some are treated on an outpatient basis through the mental health clinic or various other programs. There is no consistency throughout the VA medical care system.

There are 15 or 16 inpatient units around the country that carry out specialized programs of treatment for veterans with critical cases of PTSD. For the past three years Diagnosis Related Groups (DRGs) have negatively impacted these units.

The Vietnam veterans who are accepted into the inpatient units are those with the most severe cases of PTSD, and in most cases are only admitted after undergoing a thorough intake screening process. Upon being admitted to these programs, the veterans enter a structured program that, when initially developed, averaged 120 days from beginning to completion.

Because of the impact the DRGs were having on turning these programs into money losers, many if not all of the inpatient PTSD units were pushed to reduce the allowable length of stay from 120 days to 45 days or less. The Directors of the units were told to redesign the treatment programs to meet the allowable time frame allotted under the DRGs. Now some programs must admit a veteran for a certain number of weeks - discharge him, readmit, discharge and readmit in order to complete the treatment program.

Other units have replaced the treatment program with more of a stabilization program, which could prove disastrous, particularly in the case of veterans with severe PTSD. An important part of the program consists of dealing with and attempting to resolve Vietnam trauma issues and this cannot, or should not be done on an outpatient basis. The veterans must be kept on a ward between intense counseling sessions because of the potential for flashbacks, suicide attempts and other crisis situations that must be closely monitored by professional staff.

In addition, the DRG formulas serve as a disincentive for medical centers to establish an inpatient unit.

We understand that a possible revision is being considered by the Department of Medicine and Surgery with respect to DRGs for inpatient PTSD units. As far as The American Legion is concerned it is long overdue.

ADJUDICATION OF PTSD CLAIMS

While we are moderately pleased that there have been some improvements in the manner in which claims are handled by the VA, there are still adjudicators who are hesitant to grant service-connected disability compensation to veterans with PTSD, regardless of the amount of evidence on record or the extent to which the claims have been developed.

It is our judgment that too many valid claims are still being denied by the regional offices, and then subsequently by the Board of Veterans Appeals.

One of the recurrent problems, with respect to these cases is the fact that many times the VA psychiatric examination reports do not contain adequate military histories. Many times no attention whatsoever is given to the veteran's military duties and combat or other life-threatening situations.

In the opinion of The American Legion, additional emphasis and training is needed in both the examination process and the adjudication of claims for PTSD in a number of field stations.

CONCLUSION

In conclusion, Mr. Chairman, The American Legion will continue to monitor all activities relating to the handling of post-traumatic stress disorder by both VA medical care facilities and the regional offices. It is our intention to continue to present to

VA officials specific instances where perceived deficiencies or discrepancies exist in the diagnosis and rating decisions pertaining to claims of veterans who feel they have incurred PTSD. Our Field Representatives will also continue their evaluation of the treatment of veterans diagnosed as suffering from the symptoms of this disorder. The American Legion insists that these veterans who continue to bear the burdens of their war service are to be treated in a compassionate and objective manner.

In addition, we will continue to follow the ongoing research relating to the various aspects of PTSD, and we look forward to sharing with this Committee the findings of our own Columbia University and American Legion Vietnam Veterans Study, as we anticipate it will be published in the near future.

Mr. Chairman, that concludes our statement.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

POST-TRAUMATIC STRESS DISORDER

WASHINGTON, D. C. JULY 14, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to come before you to present the views of the Veterans of Foreign Wars of the United States with respect to Post-Traumatic Stress Disorder (PTSD). By conducting this hearing, this Committee again reaffirms its continuing concern for the health-care needs of our nation's veterans.

As you know, in January 1980, the American Psychiatric Association officially recognized PTSD as a diagnosable psychiatric disease entity. That same year, the Veterans Administration (VA) added this disability to its rating schedule and began processing PTSD claims from veterans.

PTSD can be triggered by an event or series of events in which a person experiences extreme stress. Of particular concern to the VA are those events involving combat which are life-threatening or related activity associated with

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the horror of war. The symptoms of PTSD include depression, alienation, rage, survival guilt, sleep disorders and anxiety. Associated with these symptoms but not necessarily limited to them is the impairment of the veteran's ability to interact socially which then adversely effects his ability to function in a work or family environment. It should also be noted, the symptoms of PTSD may not become apparent for many years after separation from military service, thus, making it extremely difficult to associate a particular action or event causing PTSD and one or more of its symptoms.

In preparing for this hearing, the Veterans of Foreign Wars informally surveyed our Service Officers across the country as to the timeliness and quality of care afforded veterans suffering from PTSD. While it appears the bias which previously existed toward PTSD has for the most part been removed, there does exist a lack of uniformity among the Regional Offices as to the disposition of claims--where one Regional Office may be quite liberal in granting a disability rating for PTSD while another Regional Office, using the same evidence, may be extremely conservative in granting the claim. At the same time, we discovered the degree of disability awarded also varying significantly from one Regional Office to another.

The VFW strongly believes the VA should attempt to be more uniform in its guidelines in awarding PTSD claims. We believe this can be accomplished through better coordination between and within the various components of the Department of Medicine and Surgery and increased education of fee-base physicians who are contracted by the VA to diagnose PTSD. The VFW did note that unlike the Regional Offices, the VA's Board of Veterans Appeals does show a sense of uniformity in rendering PTSD decisions. Of course, the Board is centralized thus lending itself to a more uniform record.

With respect to inpatient/outpatient treatment, the VFW is concerned about the quality of care being provided veterans suffering from PTSD. Our concerns are based on the fact that proper funding has not been provided resulting in staff reductions and, of utmost concern, program curtailment. Treatment programs that were originially six months in duration are now 60 days and, in some cases, have been reduced to only 18 or 20 days in length. This cut back in treatment can only serve to harm the veteran rather than help him. One of the major hurdles in the treatment of PTSD is the recognition that treatment is needed. Once into the program, the veteran must be allowed to complete a full course of therapy. By sending the veteran back out on the streets after 18 or 20 days of treatment, not only has any progress been lost, but that veteran, in all likelihood, will not consent to further treatment.

Furthermore, relapses increase drastically when program time is reduced. Information available to the VFW indicates that the relapse rate went from 30% on a 28-day program to 70% when that program was reduced to 21 days. The recidivism rate at one VA medical center increased by 40% when the program was reduced to 18 days. It is obvious to the VFW that in order to effectively treat PTSD patients, the VA must adequately fund and staff the program so that treatment can be of duration and quality to be effective.

In closing Mr. Chairman, much work needs to be done in fully addressing Post-Traumatic Stress Disorder. Not only must we educate ourselves to understanding the complexities surrounding this disability but we must commit ourselves to fully fund, staff and train those responsible for providing treatment to those suffering from PTSD. Attached to my statement is the VFW's current resolution addressing this issue.

Resolution No. 626

EXPAND PTSD TREATMENT PROGRAM

WHEREAS, Post-Traumatic Stress Disorder (PTSD) is a recognized residual of military combat experience; and

WHEREAS, due to an increasing recognition of Post-Traumatic Stress Disorder victims from all wars, a concentrated treatment program by the Veterans Administration is necessary; and

WHEREAS, certain Veterans Administration medical centers have already established Post-Traumatic Stress Disorder Treatment Units although such units have been hampered by limited funds; and

WHEREAS, it is essential that specialized treatment units be created in each suitable medical center in the VA system; now, therefore

BE IT RESOLVED, by the 88th National Convention of the Veterans of Foreign Wars of the United States, that we strongly support legislative or other initiatives to increase funding specifically earmarked for the establishment of Post-Traumatic Stress Disorder Units at all suitable VA medical centers.

Adopted by the 88th National Convention of the Veterans of Foreign Wars of the United States, held in New Orleans, Louisiana, August 14-21, 1987.

Resolution No. 626

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR

FOR GOVERNMENT RELATIONS

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

POST-TRAUMATIC STRESS DISORDER

JULY 14, 1988

Mr. Chairman and Members of the Committee, it is a pleasure for me to be here today to present the views of Paralyzed Veterans of America (PVA) on the incidence of Post-Traumatic Stress Disorder (PTSD) within the veteran population and the ability of the Veterans Administration to identify and treat this disability.

On behalf of the membership of PVA, I would like to express our appreciation to this Committee and to you, personally, Mr. Chairman, for recognizing PTSD as an identifiable and treatable disability. Your advocacy, even before the end of the Vietnam Era, led the Congress to enact legislation authorizing the Veterans Administration to develop new and unique treatment methods which have provided needed assistance for thousands of veterans who served in Southeast Asia.

The Vet Center program, authorized by Public Law 96-22, has served as a catalyst for the VA in developing the expertise to diagnose and treat PTSD. Indeed, Mr. Chairman, in our opinion, the VA, at times, in its squabbles over budgets, its interpretation of rules and regulations, its constriction of eligibility requirements for benefits, often appears to have forgotten its primary objective. The Vet Center program, on the other hand, is a classic example of why the VA should exist - to identify a need - to reach out - and serve the Veteran in meeting that need.

The first Vet Center opened its doors in 1980 to treat a problem that was claimed to be unique only to Vietnam Veterans. Subsequently, the knowledge and counseling techniques developed within the Vet Center program have led the VA and the general medical community to recognize that adverse reactions to severe stress and traumatic incidents can have long-lasting effects on anyone, not just Vietnam Veterans or combat veterans as a group. Counseling, particularly group counseling, techniques for individuals involved in major accidents or natural disasters appear now to be routine treatment designed to relieve the stress and anxiety of those experiences. This is still a new science which gauges the psychological, even physical, long-term reactions to stress. Much more work still needs to be done through research and clinical education. But the VA has clearly broken ground in this arena and should not miss any opportunity to capitalize on this accomplishment.

Likewise, Mr. Chairman, you and this Committee have not received sufficient credit for your efforts to advance research and treatment of PTSD. Your actions have made the VA a more compassionate place in reaching out to those veterans that it is required by law to serve. These efforts have also greatly advanced the cause of mental health science in general, benefitting the Nation and all Americans.

Incidence of Post-Traumatic Stress Disorder Within the Vietnam Era Veteran Population

The Vietnam Era veteran population is the most studied and analyzed war-time veteran population in history. In the past year alone, we have been able to review two major epidemiological studies authorized by the Congress. "The Vietnam Experience Study," conducted by the Centers for Disease Control (CDC), presented an exhaustive review of the health status and psychosocial characteristics of Vietnam Veterans and veterans who did not serve in Southeast Asia. The preliminary findings of "The National Survey of the Vietnam Generation and National Vietnam Readjustment Study," conducted by the Research Triangle Institute (RTI), are aimed at comparing the readjustment status of Vietnam Veterans, Vietnam Era Veterans and their nonveteran counterparts.

Mr. Chairman, it is vital to point out, and to underscore, that both major studies, overwhelmingly, concluded that the vast majority of men and women who served in Vietnam have made a successful reentry to civilian life. They are functioning and contributing to society on an equal basis with the rest of their generation. Too often this point is overlooked or ignored entirely in commentary, descriptions and press reports on Vietnam Veterans. As a combat veteran, having served two tours in Vietnam, I believe these study findings go a long way, and should be promoted, to clarify the perceived myths concerning Vietnam Veterans and the basic realities of exactly who Vietnam Veterans really are.

However, equally real and equally valid are the conclusions of these studies that revealed that thirteen years after the end of the Vietnam Era, there remains a certain percentage of the Vietnam Veteran population that has experienced, or continues to experience, emotional or psychosocial difficulties at rates higher than their counterparts who did not serve in Vietnam. These veterans need and deserve our help.

The CDC Study found that certain psychological problems were significantly more prevalent among Vietnam Veterans than among non-Vietnam Veterans. These included depression (4.5% of Vietnam Veterans vs. 2.3% of non-Vietnam Veterans), anxiety (4.9% vs. 3.2%), and alcohol abuse or dependence (13.7% vs. 9.2%). Significantly, 14.7% of Vietnam Veterans experienced PTSD symptoms at some time during or after military service, and 2.2% had demonstrated PTSD symptoms during the month before their examination for the study. Loosely factored to the approximatly three million veterans who served in Southeast Asia during the war, these percentages equate to an estimated 450,000 veterans with PTSD history, and 66,000 Vietnam Veterans currently exhibiting diagnosable PTSD symptoms during the 30-day period prior to their examination.

The preliminary findings of the National Vietnam Veterans Readjustment Study has confirmed the CDC conclusions. The report also corroborated the CDC's conclusion that the higher incidence and degree of psychological problems, including PTSD, among this minority of Vietnam Veterans can be directly traceable to the degree and severity of actual war zone stressors and combat experience. The study confirms that those veterans who were most heavily involved in the war had, or continue to have, far greater readjustment difficulties. The higher the degree of PTSD symptomatology the greater the likelihood of sustaining a wide variety of other problems.

The RTI Study also attempts to assess the degree to which Vietnam Veterans with PTSD symptomatology have sought professional mental health services. The results concluded that over past years a substantial proportion of theater veterans with relatively high PTSD levels have made use of either VA or non-VA services. However, the majority of male theater veterans currently experiencing high levels of PTSD symptoms have never been seen by any health professional for their PTSD symptomatology. Only 14 percent have sought mental health care in the last year.

Mr. Chairman, the results of these studies should come as no surprise. War puts intense physical and psychological demands on those who participate in it. Some individuals can more readily cope and assimilate these experiences. For others, the severity of trauma can produce both visable and invisible wounds which can, unless treated, never heal. In the past, this disorder was loosely described as "shell shock," "battle fatigue," or just plain "nervous from the service." Through the pioneering impetus of the Vet Center program and its hopefully growing influence on mental health services in the VA, we now have a name for the disability. We now have an understanding of how best to reach these veterans and provide for them the relief they need.

The nature of the war and the homecoming may have presented an unusual combination of stressors for the Vietnam Veteran. But in designing programs to assist them, we have discovered that PTSD is not unique to those who served in our last war. It is now diagnosable and treatable in military personnel currently on active duty, as well as World War II, and Korean War Veterans. For these veterans, including former prisoners-of-war, the disorder could be far more severe as it has remained untreated or mistreated for thirty or forty years.

PVA strongly believes that eligibility for readjustment counseling services should be broadened to allow access and treatment for veterans of all wars or designated armed conflicts. We would like to restate our support for Section 602 of S. 2011, recently approved by this Committee, which would achieve this purpose. We applaud the endorsement VA Administrator Thomas K. Turnage gave to this proposal when he made the following statement on March 4, 1988, in reference to the Readjustment Counseling Program before this Committee:

> Don't only treat Vietnam Veterans, treat active duty types, treat World War II types, treat Korean Veterans, or anyone else who needs that kind of help.

We would agree. A veteran in need should not be denied access to available and appropriate VA services merely based on his or her period of military service.

Vet Center Program

Mr. Chairman, just as the Vietnam Veteran has been the most studied veteran in history, the Vet Center program has been one of the most studied, analyzed and scrutinized programs in the history of the VA. In our opinion, the program has struggled through this scrutiny to be a major achievement for the

VA, of great assistance to thousands of Vietnam Veterans, and an unqualified success. It should be protected, preserved and enhanced.

As of May 1988, approximately 528,000 veterans have come to Vet Centers seeking assistance, and over 150,000 family members of veterans seeking counseling and help. Approximately, one-third, or 176,000, of those veterans seen had diagnosable PTSD according to established psychiatric standards. An additional 100,000 Vietnam Veterans seen have had PTSD symptomatology, which could be directly associated with military combat experience. According to reports, there appears to be no definitive decrease in workload activity to date. In fact, as stated before, according to the preliminary findings of the RTI study, there are a large percentage of veterans with more severe forms of PTSD who have not yet been reached by the program. We also understand that Vet Centers are currently experiencing renewed demand from clients who had received counseling one to two years ago, indicating the complicated nature of this disability, and the need for continued availability of follow-up support systems in treatment.

As with all VA health care programs, Vet Centers are being asked to provide more care and increasingly more complicated forms of care with fewer resources. Funding levels for the program at $40.5 million have remained constant for the past three years. To absorb this shortfall, even to cover nominal increasing costs, the program has had to borrow and transfer funds from its contract care operation. In FY 1987 contract funds were set at $5.5 million. In fiscal year 1989 only $5 million is budgeted for contract services.

The contract program, where properly applied, is an important adjunct to the Vet Center program. Contract Services, particularly for veterans living in rural or isolated areas might be the only available means of mental health support. PVA does not believe that these funds should continue to be allowed to be siphoned off to support general Vet Center operations. We strongly encourage this committee to monitor VA funding levels to ensure that additional funds can be provided to cover generally increasing program costs.

Coordination

Historically, the relationship between the VA Medical Center and the Vet Center has been somewhat distant due to the physical separation of the units and the treatment methodologies used by each. We understand this relationship has been strengthened significantly over the years to provide better cooperation and coordination. Even so, there is still a need to make improvements in this clinical and administrative relationship.

The physical separation of the storefront Vet Center from the traditional VA Medical Center is still a necessary and vitally important factor in the success of the program. According to reports, Vet Centers, even more so than ever before, are, and will be, facing veterans with higher and more complicated long-term PTSD problems. The community-based approach to counseling for those veterans potentially distrustful of the VA institution is essential for the provision of effective outreach and initial involvement with the VA as a health care provider. At the same time, and for the same reason, unlike the first wave of Vietnam Veterans who came to Vet Centers in the early 1980's representing a broad spectrum of veterans seeking help, those with severe or more complicated disabilities require more intense monitoring and clinical supervision. The Vet Center has a greater challenge in outreach for these veterans. At the same time, the Vet Center and VA Medical Centers must ensure that the lines of communication are open and available for proper assessment, consultation and referral to provide the appropriate care and treatment for these veterans - once they have been brought into the system.

Likewise, the Department of Medicine and Surgery and the Department of Veterans' Benefits should not stand apart in this effort. PVA has long held the view that Vet Centers, located in 188 community-based sites with direct access to thousands of veterans, are a prime asset for the VA in the delivery of a wide variety of services. In our opinion there should be better coordination between the Vet Centers and the local regional office for the purpose of claims adjudication for Vietnam Veterans. At the same time, we believe that serious consideration should be given to expanding the outreach and community support function of the Vet Centers by outstationing other VA health care and benefit services personnel at Vet Centers. Vet Centers are VA facilities. By every estimate, the needs of the veteran population are growing. The utility of Vet Centers in the community should not be underestimated in the role of social services, medical care, mental health services or benefit delivery.

PTSD Inpatient Units

Over past years, the VA has designed and the Congress has supported the operation of specialized inpatient PTSD treatment units at several VA Medical Centers across the country. PVA supports this effort which is designed to provide intensive counseling and therapy over an extended period of time for more seriously troubled veterans. However, we have several concerns with the operation of these programs.

First, in our opinion, most individual inpatient treatment teams have developed innovative programs. However, this progress is not consistent among all identified inpatient units. The Chief Medical Director's special Committee on Post-Traumatic Disorder has recommended specific guidelines for treatment, operations, and coordination for these units. PVA concurs with this recommendation.

The quality of care and thrust of treatment methods does seem to vary from unit to unit. The inpatient treatment teams should have a better opportunity to coordinate with each other from a clinical standpoint.

The VA's Mental Health and Behavioral Sciences Service should also make a thorough review of the inpatient unit's operation to assess if additional resources should be allocated to individual units or resources transferred to other VA Medical Centers wishing to establish new treatment programs. We have also been concerned that there remains, in certain areas, a major gap in coordination, referral and follow-up between certain Vet Centers and the inpatient treatment facilities at their parent VA Medical Centers. Ideally, the Vet Center should work closely with the inpatient team in all aspects of treatment. The Vet Center is the first point of contact and referral for the veteran. It should be involved from that point in all aspects of pre and post discharge care to ensure the continuity of treatment and adequate follow-up.

National Center for Stress Recovery

The Congress, as stipulated in Public Law 98-528, authorized the VA to establish a National Center for Stress Recovery (CSR) which was to become a National Center for excellence for clinical treatment, education and research on PTSD. As designed, the CSR was to become an operational clinical unit and also a national clearinghouse to coordinate treatment methodologies among other VA PTSD inpatient units and disseminate this information both within and outside the VA.

Unfortunately, in PVA's opinion, the original center, located at the Brecksville, Ohio, VAMC, has not lived up to these expectations. We understand the VA is planning to move the Center from Brecksville and is circulating a proposal to other VAMC's interested in accepting this opportunity. PVA believes this should be an immediate priority for the agency. The new Center should be quickly reestablished according to its original mandate.

The VA should provide sufficient staffing and funding for the Center to assist in the coordination of the many disparate and far flung PTSD activities within the VA. The Center should also be strengthened to improve its outreach mission of disseminating information on PTSD clinical education and research to the non-VA health care community at large.

As we have stated before, VA PTSD activities rank as a major accomplishment and opportunity for the VA to help the veteran and to advance the cause of medical science. As a starting point for the inauguration of the new Center for Stress Recovery, we suggest that the VA sponsor an International

Conference on Post-Traumatic Stress Disorder to highlight its own achievements and to bring internationally recognized mental health clinicians and researchers together to discuss the current state-of-the-art in the study and treatment of stress reactions.

Research and Education, and Training

Mr. Chairman, in commending the VA for its activities in the field of PTSD, PVA believes there is also room for criticism. We do not believe that enough is being done to advance clinical research, education and training in this field. While the Readjustment Counseling Service has improved its training program for its own personnel over the years, more should be done to coordinate additional training for both Vet Center and other VAMC health care professionals. The result can only provide additional quality assurance and standardization of treatment within the VA as a whole.

PTSD Compensation

According to VA reports, as of February 24, 1988, the VA, since 1985, had reviewed 26,529 claims for service-connection for PTSD and approved 14,531 or 54.8 percent. These statistics clearly show that the agency has improved its ability to properly diagnose, review and approve a PTSD claim. At the same time, we have heard reports that there is still a lack of adequate coordination between Vet Centers and Regional Office personnel in certain instances in assisting with the development of a veteran's claim. We are also concerned by reports of dramatic inconsistencies in approval rates and disability rates granted for PTSD from one Regional Office to another. These inconsistencies must be corrected. We believe that appropriate standards and guidelines for PTSD claims adjudication must be set and adhered to. VA adjudicators handling PTSD claims at the Regional Office level and the Board of Veterans' Appeals must be fully exposed to adequate training, both within the Department of Veterans' Benefits and through the PTSD training program conducted by the Department of Medicine and Surgery.

The Chief Medical Director's Special Committee on PTSD

PVA would like to commend the Members of the Special Committee on PTSD. Over the years the Committee has demonstrated great dedication and attention to detail in monitoring the VA's growing mission in the study and treatment of stress disorders. We understand that, while the mandate for the Committee to function in its oversight capacity will continue, its requirement to report recommendations has lapsed with the issuance of its released fourth Annual Report. We recommend that the Committee's reporting requirement be reinstated and extended. The Special Committee's reports have provided excellent advice and insight into the daily operation of Vet Centers and all VA PTSD-related activities. The Congress, the VA and the veteran community should continue to have access to the Committee and the Committee's formal views.

Mr. Chairman, this concludes my testimony. I will be happy to respond to any questions you might have.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA, INC.

Presented By

STEVE BENTLEY
NATIONAL CHAIRMAN

VVA SPECIAL COMMITTEE ON PTSD
AND SUBSTANCE ABUSE

and

THOMAS A. SHERWOOD
NATIONAL DIRECTOR OF
HEALTH POLICY AND PLANNING

before the

SENATE COMMITTEE ON VETERANS AFFAIRS

on

POST TRAUMATIC STRESS DISORDER

JULY 14, 1988

★ A not-for-profit national veterans' service organization ★

Mr. Chairman and members of the Committee, the Vietnam Veterans of America, Inc. (VVA) appreciates this opportunity to express its views on the subject of Post Traumatic Stress Disorder (PTSD) at today's oversight hearing. It is well that this hearing is being held, because it should afford an opportunity to see what the VA has accomplished and in what direction the VA should now go in addressing the treatment needs of veterans with PTSD. This particular area of inquiry is about one year overdue. Given the distraction last year when the VA attempted to prematurely begin the process of converting the "Vet Center" program from a store front-based program to a VAMC-based program, it was impossible to examine the issue of PTSD in a productive fashion.

According to Dr. John E. Helzer in his study in the New England Journal of Medicine on Post Traumatic Stress Disorder (PTSD) Dec., 1987, Vietnam War veterans wounded in combat are nearly six times as likely to suffer lasting effects of PTSD as victims of beatings, muggings, rapes and other violence. Further, persons in the study with PTSD were at least twice as likely as those without it to have some other psychiatric disorder. The Diagnostic and Statistical Manual of Mental Disorders (third edition - revised), May 1987, or simply the DSM-III-R, recognizes PTSD as an entity unto itself whose essential feature "is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience." Current literature and findings clearly suggest that more veterans of all wars, here and abroad, are victims of PTSD in varying degrees of intensity than was realized. Current legislative initiatives which recognize PTSD and PTSD related disorders in American veterans of earlier wars have finally through that recognition vindicated many of our veterans who have suffered in silence for too long.

The emerging full recognition of the ravages of PTSD has produced a real challenge to the VA in providing care for those veterans who are affected. This challenge has to a great degree been articulated in the three annual reports by the Chief Medical Director's Special Committee on PTSD, the third and final report having become public in February, 1987. To date, many aspects of providing care to PTSD victims have been identified as sources of concern which the VA needs to address. Some of these include programs, funding for programs, quality of programs, eligibility for services, compensation and pension, and a range of other related services. In this statement we will address what we believe to be the most important aspects concerning PTSD services for our veterans.

PTSD FUNDING: READJUSTMENT COUNSELING SERVICE (RCS) - THE VETERANS OUTREACH CENTERS

As we have noted in previous testimony this year, especially when the VA proposed to cut the $42 million program by what would have amounted to over $13 million for fiscal year 1989, the outreach program which provides extensive service in the care of veterans with PTSD is a program that works and therefore whose funding need not only be protected but augmented. Of the $42 million allocated for the RCS program, approximately $5 million is allocated for contract services in the community for counseling veterans who are suffering with PTSD.

Because of inflation and increased salaries for the staff in the 189 vet centers, the original amount of contract dollars available has fallen from as high as $8 million to $5 million and is still declining. In other words the valuable services being provided to our veterans on a contractual basis are being cut at the expense of the larger budget of a program which is equally as important. Given the obvious and real need in this situation, we strongly recommend that the VA's RCS budget at least match the real dollars lost through salary adjustment and inflation over the last three years. We are aware that six new vet centers may be coming on line for fiscal years 1989 and 1990 and are hopeful that these will be adequately funded. However, the reality is that as PTSD continues to be recognized as the pernicious illness that it is, the RCS will have to be expanded as well as fully funded. Against this background, the VA continues to ignore the underfunding of mental health in general while 22 percent of all outpatient visits are psychiatric, 20 percent of all inpatient beds are psychiatric and 40 percent of all beds in the system are filled with veterans with a psychiatric disorder, according to Dr. Kenneth L. Davis who has testified before this committee. Meanwhile, as we understand it, about 24 percent of the VA's in-patient health resources are targeted toward mental health.

CONTRACT HALFWAY HOUSES FOR PTSD

Contracting for halfway house care of veterans with PTSD in the community is an initiative that the VA can be proud of and should do everything in its power to maintain the program. Under appropriate VA oversight and with good community programs, such a program gives the veteran an opportunity to help him/herself to reintegrate into the community while dealing with PTSD and readjustment. At the same time, such houses afford an excellent step-down option among others for the veteran leaving an inpatient hospital PTSD program. However, what we have found is that these programs funded from VAMC resources, are highly vulnerable to discontinuity when budget cuts in individual VAMC's are ordered up. This is especially unfortunate given the overall size of a given VAMC Budget by contrast the small cost and enormous benefit these programs provide for the veteran. It is our earnest hope that the value of these programs be recognized relative to the small investment made by the VA. We urge the committee to foster stability in the funding of these programs so as to allow continuity of services over time. Currently these services operate with uncertainty on a day to day basis. This leads to considerable instability and disruption.

PTSD: IN-PATIENT PROGRAMS

Currently there appears to be about 14 in-patient PTSD units throughout the VA involving approximately 523 beds. In many cases those units have been a great challenge for both the VAMC and the veteran. The VVA is concerned about the considerable variability among these programs especially with regard to average lengths of stay, lack of manpower assigned to these programs, lack of clinical and management organization in a few of these programs, and the need for these programs to clarify goals and objectives. There remains a need to assure appropriate standards of clinical practice including allowing the veteran patient and relative or significant others to participate in the clinical process. To quote recommendation Number 6 of the CMD's Special Committee on PTSD,

> "Minimal standards of care for special in-patient PTSD units should be clarified in the VA's forthcoming program guides and should be monitored periodically through the VA's Quality Assurance Program, the SERP review process or through specific site visits."

From the same Special Committee's report recommendation Number 7, it is noted that "because of the adverse fiscal impact of the current Resource Allocation Model (RAM) upon VAMC's operating specialized in-patient PTSD units, the Special Committee recommends that more realistic and equitable reimbursement formulae be developed without delay." In short, VAMC's are not adequately reimbursed per day of care per PTSD patient on the unit relative to the quality and quantity of staff required to care for such a patient. Again, this issue points out the unfair lack of funding of mental health programs relative to the care required and given for the mentally or psychiatrically disabled.

Regarding the great variability in the length of stay which can range between 1 day and 3 months or more, it becomes apparent that basic standardization in the form of assessment, diagnosis, screening, admission and discharge protocols should be developed.

With such clinical and administrative standardization, it may be discovered that in-patient PTSD management may be better served with fewer beds per site but with greater numbers of PTSD units throughout the system. In terms of resources and capability, the inpatient PTSD units at Menlo Park and Brecksville are still perceived as setting the standard for the quality of care and delivery. It may be very useful to use this unit as a model to set the standard throughout the system. The VVA supports the addition of PTSD inpatient beds to include a unit in each district with the understanding that these units be well designed, staffed, supported and clinically, as well as administratively, managed with complete veteran patient participation. Further, these units should be fully intergrated with step-down outpatient ambulatory care strategies. Some of these would include contract

PTSD care and follow-up, RCS outreach center care and follow-up, outpatient mental health care and halfway housing or home based PTSD care and follow-up. It would be helpful, in this connection, if these were clinically interlocking systems so that tracking, follow-up and referral services could be coordinated to the greatest advantage of the veteran. Additionally, all VAMCs may not need an in-patient PTSD treatment program, however, all VAMCs have some veterans that may be suffering from some form of PTSD. Therefore, VVA would support at least some FTEE at each VAMC for those veterans with PTSD problems. A team of perhaps two FTEE in each VAMC to serve in a training and awareness capacity should be seriously considered.

PTSD AND THE INCARCERATED VETERAN

It has been estimated that between 20 percent and 50 percent of all combat Vietnam veterans are affected with some form or component of PTSD. Estimates going back to 1978 have been made that as many as 750,000 Vietnam veterans needed assistance in dealing with the combat experience.

With this in mind, the VVA invites this Committee's attention to the ramifications these numbers hold for the incarcerated Vietnam veteran. Without making any categorical judgements as to the influence PTSD may have had on the behavior of these veterans that caused their incarceration, it does seem appropriate and long overdue that some attention be paid to this subject.

As veterans, these individuals may be in just as great or greater need of PTSD counseling as any other veteran. Assuming that our penal system still entertains the principle of rehabilitation as a primary purpose for incarceration, PTSD treatment for these veterans constitutes a significant unmet need. According to Dr. Charles Figley, a marine Vietnam veteran who is a professor of family therapy and psychology and who is a long time expert on PTSD, "I think there are lots of people who are in prison who shouldn't be, because when they were found in the criminal activity it was associated with Vietnam."

Under the circumstances, the VA could play a large role in addressing the treatment needs of incarcerated veterans with PTSD. Being the lead federal agency in the area of PTSD treatment, we believe it is appropriate to expect the VA to play a far more active role. Moreover, in connection with the peculiar problems common to veterans, the VA should also be lending assistance to incarcerated veterans with problems other than PTSD. This could be especially important to the veteran about to be paroled or released but who has no post release plan in place.

What is provided to these veterans is inconsistant and lacking policy direction. Some local VAMC's have provided limited outreach for provision of health services. Others have avoided provisions of services of any kind as long as the veteran is in prison. In our view, it would be useful to know, as a matter of VA policy, what legal authorities exist which would allow the VA to become more involved. For example, what kind of services, if any, can the VA provide? What conditions might better facilitate VA provision of services? What limitations prevent more outreach from VAMC's or Vet Centers? Does the VA have the authority to enter into agreements or memoranda of understanding with penal institutions or local services providers? Where insufficent authority exists, serious consideration should be given to providing it.

Irving M. Allen, MD in Hospital and Community Psychiatry, January 1986 notes that "incarcerated men should be routinely screened for combat history." Were the VA's mission toward incarcerated veterans more clearly delineated, the agency might be able to offer assistance to penal facilities when combat veterans likely to have PTSD are identified.

In examining this matter, we urge the Committee to carefully consider the merits of stimulating a VA policy including the following:

* Regular VA outreach assistance to penal facilities for the purpose of assisting these institutions and the veterans in them with PTSD, substance abuse, family and readjustment counseling.
* Assistance in sensitizing prison staff as to the symptoms and behavioral problems likely to appear in veterans with PTSD.
* Assistance in developing post prison strategies as a policy for incarcerated veterans including vocational rehabilitation education and continued treatment for PTSD if needed.
* Assistance in developing an accurate data base on incarcerated veterans.

SUBSTANCE ABUSE AND PTSD

Thus far in this statement we have focused our attention on the problems associated with shortages of resources in the provision of varied treatments for PTSD. However, there is an additional concern for a problem in the actual treatment available to veterans afflicted with both PTSD and substance abuse.

Vietnam Veterans of America has put together a National committee which is made up of eighteen professional men and women with a wide range and depth of experience around PTSD and substance abuse. Consultants to this group include such prominent doctors as Tom Williams, Jack Smith, Matthew Friedman, and Joel Brende. It is the contention of this committee that there is a strong correlation between alcohol and/or drug related problems and the symptoms of PTSD as they are experienced by Vietnam veterans. This correlation and its negative impact on effective treatment outcome and successful readjustment for many combat veterans has generally not been recognized, either in clinical literature or in treatment programs utilized by veterans, whether in the public or private sectors. Veterans experiencing readjustment difficulties may be suffering, not just from PTSD, nor just from chemical dependency, but very often from both conditions, which in a vicious cycle may be simultaneously exacerbating the negative effects of both PTSD and chemical dependency symptoms. Treatment programs for Vietnam veterans suffering from PTSD and chemical dependency which address only one of the conditions, ignoring or minimizing attention to the other, are often doomed to failure. Either the veteran will use his/her abusive use of alcohol and/or drugs to sabotage successful readjustment from PTSD, or he/she will use unrelieved symptoms and issues from PTSD as a rationale to continue abusing alcohol and/or drugs in a survival mechanism of self-medication.

Experts estimate that eighty percent or more of the 500,000 to one million men and women that are experiencing significant to severe readjustment problems are either exacerbating these problems with substance abuse or having their chronic substance abuse intensified by unresolved Vietnam issues. The National Institute of Alcohol Abuse estimates that each individual alcoholic significantly affects at least four other lives. In our professional experience the same ratio applies to Vietnam veterans with emotional/psychological difficulties and substance abuse. In presentations to high school and college classes, we have learned dramatically that the devastating emotional after-effects of the Vietnam war have often passed from fathers to children. Even as more and more researchers and experienced professionals are recognizing the insidious relationship between PTSD and substance abuse, to date there has been no concerted effort at dealing with these dual manifestations and their far-reaching and tragic consequences. There is presently no consistent consensus of how to approach this void anywhere within the existing system of PTSD units and vet centers in the VA.

The tragedy is that we can fill trailer trucks with the knowledge we have on PTSD as well as what is known about alcoholism and drug addiction. However, the research done on the two together would fit in the glove compartment of a car. One negative dynamic is that the two treatment modalities are in professional and financial competition with each other and so we not only have a dual diagnosis problem, we have a dueling diagnosis problem -- turf battles in which the veteran is the loser. Alcohol treatment that denies a veteran his or her experience of Vietnam is unpardonable. By the same token, any program that hopes to treat PTSD must be equipped to deal with the related condition of continued substance abuse.

STATEMENT BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

BY

ALBERT J. BLAND, NATIONAL COMMANDER

AND

CHARLES M. WILLIAMS, EXECUTIVE DIRECTOR

AMERICAN EX-PRISONERS OF WAR

WITH RESPECT TO

OVERSIGHT HEARINGS

ON

POST-TRAUMATIC STRESS DISORDER (PTSD)

WASHINGTON, D.C. JULY 14, 1988

Mr. Chairman and Distinguished Members of the Committee.

It is an interesting coincidence that the Committee selected July 14th for this important hearing. As you know, it is also Bastille Day, celebrated by the French for liberating thousands of citizens who suffered extreme and prolonged trauma during their confinement by the French Monarchy. The long-term consequences were never assessed but few would deny they persisted.

Similarly, we have appended an informative article on Prison Ships During the American Revolution originally published in the DAR Magazine in 1956. It details in stark language the brutal trauma inflicted on our first patriots. Again, the long-term consequences were never assessed but few would deny they persisted.

This background puts in better focus the tragic fact that those who "bore the battle" in all our wars have always paid an extreme price in enduring psychological damage to their minds in addition to any physical damage to their bodies.

Understanding the scope and nature of the psychological damage—and its persistence throughout later life—has only begun in recent years. And there is much more still to be learned.

Indeed, the most recent research on Vietnam Veterans informs us that those subjected to severe combat stress will experience common adverse psychological consequences regardless of individual differences in basic personality structures.

Trauma leaves its mark! And it is an enduring mark!

Post-traumatic Stress Disorder (PTSD) is a specific pattern of psychiatric symptoms that characterizes many veterans of the Vietnam Conflict, but is by no means a disorder restricted to that war. We note with deep appreciation to the Veterans Administration that all former prisoners of war have been specifically invited to participate in VN Outreach Centers. Indeed, many VA medical facilities have also established special groups where POWs can attempt to work through the still-intense traumatic residuals suffered more than forty years earlier.

The first point we are making is to reinforce the fact that traumatic residuals remain a major a major and life-long problem for many combat veterans—and a continuing challenge to VA. Earlier myths that stress-produced anxiety simply fade away over time have at last been thoroughly debunked.

Our second point, is that research, as well as anecdotical material, indicates suppressed anxiety from earlier combat experiences often resurfaces much later in life. As coping skills of individuals gradually diminish due to health and living problems associated with aging, this anxiety can increasingly surface and disrupt functioning.

Mr. Chairman, we believe this is an issue that has not yet been fully understood or addressed in the broad planning efforts by Congress and VA.

We believe there is a need for outreach efforts to identifying older veterans confronted with these belated stress reactions—and to provide brief therapeutic services as those so successfully provided to VN Veterans via the outreach centers. We believe that the National Center for Stress Recovery at the Cleveland VAMC should be provided the resources to broaden its leadership efforts in this respect.

We are convinced that readily available assistance to older veterans experiencing PTSD-like delayed reactions can serve an important preventative function in the sense of limiting the disrupting impact of such delayed stress reactions both on the veteran and family members.

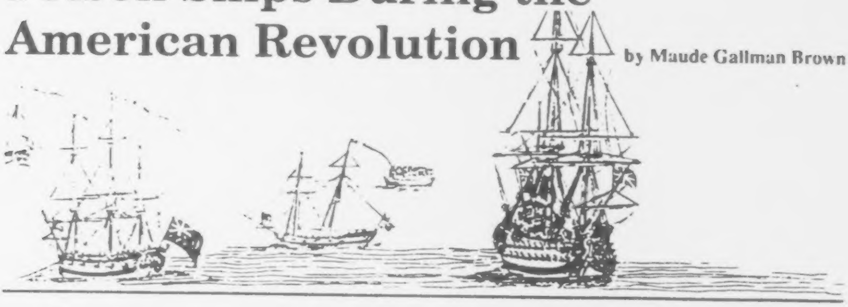
The bottom-line objective is to enable these veterans to develop additional stress-management skills to replace or buttress those that are failing during their later life. This is a worthwhile challenge to VA and service to veterans who served their country so well on battlefields everywhere.

Thank you.

Attachment.

Prison Ships During the American Revolution

by Maude Gallman Brown

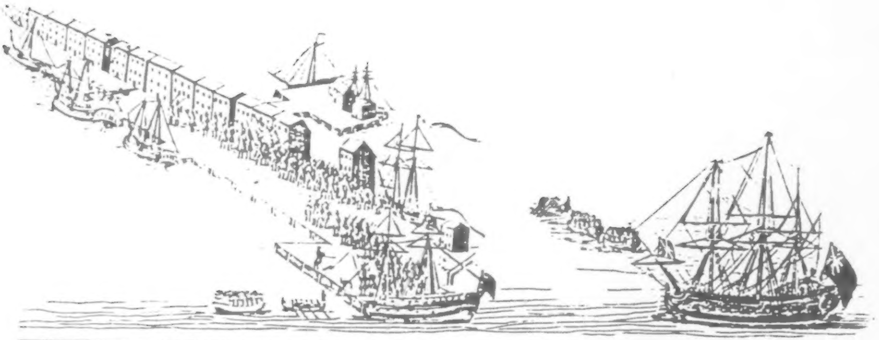


EDITOR'S NOTE: This article reprinted from the Giles County, TN, Historical Society Bulletin, which reprinted it from DAR Magazine, November 1956. It was submitted to the EX-POW BULLETIN by Darrell Russel of Florence, AL.

Life for prisoners of war has never been easy. Aside from confinement, hard in itself, there is always the boredom of inactivity; hopelessness from lack of information; anxiety for loved ones and the impossible wish to comfort them concerning himself. Capture meant all these things to our ancestors, who participated in the American Revolution. Our fighting men were considered traitors so that capture could mean trial for treason. Also it could mean confinement on a British prison ship stationed in Wallabout Bay, site of the present Navy Yard at Brooklyn, NY. Most of the prisoners taken at sea were confined in these floating prisons.

Why England elected to use ships for prisons is not known since she had many buildings in New York, which could have served as prisons, as in fact some of them did. It is also difficult to reconcile the treatment accorded captured patriots with the usually humane character of the British in command. Their resources at New York are not deemed to have been a factor. Whatever the reason, the situation was so bad that on January 13, 1777, General Washington wrote Admiral Howe protesting the cruel treatment of prisoners and stating he had been advised prisoners were offered better treatment if they would enlist in the British service. Admiral Howe replied that some prisoners having escaped, less freedom was allowed others. However, Gen. Washington was so little impressed with this answer that he wrote Congress so many prisoners released by the British were unfit for exchange because of the severe treatment they had received, a deduction should be made on their account.

The inexperience and overzealousness of the privateers added greatly to the list of American prisoners taken at sea. The Continental Congress authorized privateering March 23, 1776, and on April 2nd and 3rd adopted a form of Commission for privateers giving bond. "Letters of Marque," so called from the letters or commissions they carried, were armed trading vessels authorized to take prizes. They also were generally and more properly called privateers. Optimistic colonists would sometimes pile into a small unarmed sloop and with muskets and pikes attempt to take a larger British vessel. Even "sober-sided" patriots would set out in vessels of less than twenty tons with ten or fifteen men and boys for crew, hoping to make their fortune by a lucky capture. As prisoners these men were likely to join others in the prison ships anchored in the East River between New York and Brooklyn.



In 1776 William Bary, a prisoner on the *Roebuck* in Delaware Bay, and Elisha Cole, an American shipmaster on the frigate *Milford*, were impressed into service and forced to bear arms against their countrymen. Capt. Daniel Lunt of Newburyport was well treated on board the British cruiser, *Lively*, which captured him off Cape Ann in 1776, but afterwards he transferred to the *Renown* and was robbed of his money and put at hard labor.

In June 1778 Robert Sheffield, a shipmaster of Stonington, Connecticut, made his escape from a New York prison ship after six days. He said there were three hundred and fifty men on board confined below and that the heat was so intense they were all naked. Some were delirious, raving and storming; some groaning and dying, all panting for breath. The air was so foul at times a lamp could not be kept burning by reason of which the boys were not missed until they had been dead ten days. There were five or six deaths per day.

Capt. Conyngham wrote of his experience December 1, 1779: "I was told to get ready to go on board the prison ship. Then a pair of criminal irons were put on my legs, weight 50 pounds. At the door I was put into the hangman's cart, all in form as if bound to the gallows. I was then put into a boat and took alongside the *Raisonable* to be sent to England in the packet. In those irons I was brought to Pendennis Castle. Then not contented, they manacled my hands with a new fashioned pair of ruffles very tight. In this condition I was kept 15 to 16 days, then brought to Plymouth and lodged in the black hole for eight days, before they would do me the honour of committing me on suspicion of high treason on His Majesty's high seas. I was then put in Old Mill Prison were we committed treason through His Majesty's earth and made our escape."

Most notorious of all prison ships was the *Jersey*, an old 64-gun ship of the line, which had been surveyed out of His Majesty's service. Very little mention is made of the *Jersey* in our literature, yet she was more feared by American patriots than England's infamous Old Mill Prison because conditions were more tolerable in Old Mill Prison than on the *Jersey*. However, the two had two things in common: a man rarely escaped from either, and the treatment endured generated a lasting hatred of everything British.

The *Jersey* was, indeed, a derelict among derelicts. Her calking had fallen out and the wind blew snow through the cracks. There was never enough food and seldom enough water. As many as 1200 prisoners were confined aboard her at one time. During the day they were permitted on deck, but at night everyone had to go below without regard for their condition. The air was so foul and nauseous that it was considered a privilege to sleep near one of the holes in the sides of the ship. The sick were doubtless made sicker and the dying were speeded on their way by the heat, the vermin and the stench. Dysentery, smallpox and yellow fever were prevalent and helped to produce an appalling death rate.

Several hospital ships were also anchored in the East River near the *Jersey* and were packed with prisoners from her. Unfortunately the attendants were colonists who had become hardened to suffering, drunkards as well, and were always anxious to rob the dead. Contemporary writers estimated that eleven thousand American seamen died aboard the *Jersey* and companion hospital ships during the years of her service.

In the fall of 1780, Capt. Silas Talbot was confined on the *Jersey*. There were then about 1100 prisoners on board with no berths to lie in and no benches to sit on. Dysentery and fever were prevalent. The weather was cool and dry with frosty nights so that the number of deaths was reduced to about ten a day.

Philip Freneau, the poet, wrote of an unsuccessful attempt to escape: "The sentries posted themselves at each hatchway and most basely and cowardly fired for and aft among us, pistols and muskets, for a full quarter of an hour without intermission. The next morning all that were found

PRISON SHIPS DURING THE AMERICAN REVOLUTION, cont'd...

wounded were put in irons and ordered to lie upon deck, exposed to the burning sun. About four o'clock p.m., one of the poor fellows who had been wounded the night before died."

Conditions seem to have improved a little in 1781 when Ebenezer Fox was a prisoner there and he states their ration allowance was two-thirds that of a British seaman, although far from equal in quality. The bill of fare was a follows:

Sunday —	1 lb. of biscuit 1 lb. of pork 1/2 pint of peas
Monday —	1 lb. of biscuit 1 pint of oatmeal 2 ounces of butter
Tuesday —	1 lb. of biscuit 2 lbs. of salt beef
Wednesday —	1-1/2 lbs. of flour 2 ounces suet
Thursday —	Same as Sunday
Friday —	Same as Monday
Saturday —	Same as Tuesday

The cooking for the prisoners was done in a great copper vessel that contained between two and three hogsheads of water, set in brick work. It was square and divided into two compartments by a partition. In one of these compartments the peas and oatmeal were boiled in fresh water. In the other compartment the meat was boiled in salt water taken from alongside the ship. (The *Jersey* was anchored near the shore, imbedded in mud. All the refuse that accumulated among upwards of a thousand men was daily thrown overboard and would remain there until carried away by the tide. The impurity of the water can be imagined. In this water the meat was cooked.)

The only fuel available for cooking was green chestnut so that when the fire was started at seven in the morning it was impossible to get the pot to boil before noon, and on stormy days it took until three in the afternoon.

Thomas Andros was on the *Jersey* in 1781 and said, "Now and then an American physician was brought in as a captive, but if he could obtain his parole he left the ship, and no one blamed him, for his own death was next to certain and his success in saving others by medicine in our situation was small. No English physician or anyone from the city ever to my knowledge came near us. Our bread was bad in the superlative degree — full of living vermin, but eat it, worms and all, we must or starve."

It might be noted that the population of Long Island was mostly Tory which accounted for the indifference of the townspeople, although as early as 1777 subscription books were opened in many parts of England for the relief of American prisoners there. Aside from the fund raised in England, Benjamin Franklin sent over what money he could spare to be used for the benefit of the prisoners. However it was discovered within a few years that the purported American merchant in London named Digges to whom the money had been entrusted, was in fact a British spy and had embezzled nearly all the money received for the relief of our prisoners.

As we think upon the unhappy plight of our gallant ancestors it serves to remind us that freedom has always been hardly won, and that each generation must, if necessary, fight to preserve that freedom and hand it on to posterity.

END

Vet Center
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Portland, ME 04101
780-3584

DATE: JULY 21, 1988
TO: ELIZABETH M. BUECHLER, ASSOCIATE COUNSEL
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
FROM: ROBERT E. COMEAU, LCSW
TEAM LEADER, PORTLAND VET CENTER
SUBJ: WRITTEN RESPONSE TO QUESTIONS FROM PTSD OVERSITE HEARING
JULY 14, 1988

1. Before I begin my written response to your questions, I would like to express my appreciation to the Chairman, Senator Cranston, and to Senator Mitchell for inviting me to testify at the PTSD Oversite hearing held on July 14, 1988.

2. I was hired as a Social Work Associate GS 5/1 on November 18, 1979 as a staff member of the Portland Vet Center, part of the new nationwide Vet Center Program established by PL9622. During my career with the Vet Center Program, I earned my MSW degree as a part time student at the University of Connecticut and have worked my way up to Readjustment Counseling Therapist/Team Leader GS 12/3. I have recently been licensed as a Licensed Clinical Social Worker. I am therefore qualified by education and experience to provide readjustment counseling to Vietnam veterans suffering from PTSD. My military experience includes a tour of duty as a Hospital Corpsman Second Class with the 3rd Battalion, 11th Marine Regiment, during which time I was responsible for the emergency medical care of a company of Marines.

3. "It was noted that there is a relatively low utilization by minorities and women of VA sponsored services for PTSD, including Vet Center services. Do you agree with that assessment?"

Minority veterans have been comparatively well represented in our caseload at the Portland Vet Center, even though they currently represent a small percentage of the population. They are moving into Maine in increasingly large numbers and slowly changing the demographics of this state. I have asked minority veterans about their feelings towards the Veterans Administration and the Vet Center Program. They express a willingness to utilize the benefits counseling aspect of the Vet Center Program, but do not feel comfortable with treatment issues. Black Vietnam veterans, especially, have been resistant to discussing combat issues with white counselors and have not joined a white combat group, though they readily work with the same counselors on other issues.

Despite the advantage of having professional women on both our Vet Center and Contract Fee Service staffs, we have had little success at attracting female Vietnam veterans to the Vet Center Program. Women with Vietnam experience are reluctant to become involved with what they perceive is a male-dominated program, and nurses with Vietnam experience often do not wish to recreate their former healing and leadership roles at a Vet Center. I have made a special effort to make private, individual counseling available outside of the Vet Center to any female Vietnam-era veteran who requests it, and to identify and outreach potential female veteran clients.

I feel that special efforts are needed to reach out to minority and female veterans. Funds should be made available to hire consultants from within the community to assist the Vet Center Program in gaining access to these populations. The VA might consider a special program of paid advertising aimed at minority and female veterans, to encourage them to become involved.

4. "Do you have any comments on the findings of the RTI study that 471,000 Vietnam Theatre Veterans are currently suffering from PTSD?"

In my experience, I have found that the Vietnam veterans with the most combat experience and greatest need for PTSD treatment are often the least likely to ask for it. I have spoken to many Vietnam veterans who have good jobs and live in stable families, yet suffer constantly from PTSD symptoms that they are ashamed to admit having because people in authority whom they trust tell them that they should be all right.

It does not surprise me then, that 471,00 Vietnam combat veterans are currently suffering symptoms of PTSD and have not been in contact with the Vet Center Program or the VA. Despite our early attempts at innovation, the Vet Center Program has has to adopt a medical model of PTSD treatment to stay credible within the VA medical community. This model requires that quality assured treatment following an approved treatment plan be given on an individual, family or group basis to qualified Vietnam-era veterans as appropriate. Following this model, small professional staffs such as ours quickly fill all available hours with clinical appointments. This makes outreach difficult as we do not want to increase Vietnam veteran's expectations of quality treatment for PTSD when staff time is not available. We have had to learn to balance outreach activities and clinical time or risk client dissatisfaction and staff burnout.

More outreach could be accomplished by outstationing Outreach Specialists at a distance from Vet Centers. In Maine, this could be easily accomplished with the assistance of the Maine Department of Labor. The Portland Vet Center presently outstations one temporary Outreach Specialist at the Lewiston Job Service office one half day a week with good results. Additional staff might be able to use other Job Service offices around the state as itinerate points to provide outreach and some referral services to Vietnam-era veterans. Cost for this aspect of the program would be based on salary and local travel requirements rather than rent etc. A lessening of restrictions on the Contract Fee Service part of the Vet Center Program would enable outstationed Outreach Specialists to provide therapy to those Vietnam veterans unable to travel to a Vet Center or VA Medical Center

5. "To what extent are your centers generally capable of providing appropriate treatment services to veterans with PTSD? Are there certain levels of severity of PTSD which are and are not appropriate to treat at Vet Centers---and does the capability of Vet Centers vary in this respect."

The ability of individual Vet Centers to treat PTSD varies with the staffing of that center and to the experience level of the treatment staff. Most, if not all Vet Centers have at least one qualified individual on their treatment team. This has been a requirement for at least two years. We in Portland are fortunate to have the services of three qualified individuals on staff and excellent consultants to assist us. We feel confident in treating any PTSD case that can be treated in an outpatient situation. Those individuals who represent a danger to themselves or others are hospitalized whenever possible.

Severe PTSD can be a complicated, time consuming treatment situation. Often, clients who exhibit the most severe PTSD symptoms such as: repeated flashbacks; inability to sleep; recurring nightmares; and isolation require hospitalization. Less severe cases may be seen several times during the week and often for extended periods during the day. These cases are difficult for the staff because they require shifting client schedules to work around emergent situations. Moderate cases of PTSD can often be seen in group, which is the most efficient treatment method from a man-hour perspective, but requires the most experienced therapist. An important issue here is the total time required for effective treatment of PTSD. In severe case, this may be measured in years, while in the least severe cases, good resolution might be accomplished in a matter of weeks.

6. "Please describe the adequacy of the training you and your staff have been provided to deal with the problems of veterans suffering from PTSD and substance abuse."

We have received a mixed message regarding this issue. We have been told that we are not supposed to be treating veterans with substance abuse problems and that these veterans should be referred to VA Chemical Dependency Treatment Units. Our training and experience ranges from highly experienced to moderately experienced with one staff member well qualified to lecture on the subject of PTSD/Substance Abuse. All staff members have had professional training in substance abuse at this time which they had acquired on their own. We have worked closely with other agencies to provide the best possible information and referral to veterans with substance abuse problems. We consider ourselves to be adequately trained at this time.

7. "What suggestions do you have for making improvements in the capability of Vet Centers and of VA treatment programs generally to deal with these dual disabilities."

An important area of difference that should be resolved in one involving basic philosophy. Vietnam combat veterans with substance abuse problems often complain that their Vietnam history and reactions to combat are not taken into account during substance abuse treatment. Joint training between the staffs of Vet Centers and Chemical Dependency Treatment Units might help both staffs work through their differences on this important issue. We need to work out joint treatment plans that take into account the intricacies of PTSD and substance abuse. Presently, the Portland Vet Center has an ongoing group for veterans with a dual diagnosis of PTSD and substance abuse. Perhaps this model could be used in future trainings.

I appreciate the opportunity to respond in writing to your questions.

Robert E. Comeau
ROBERT E. COMEAU, LCSW

CC:
10B/RC
10B/RC1
402/116B
file

Vietnam Veteran
Resource Center

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(504) 943-8386 FTS: 682-5473

July 26, 1988

Ms. Elizabeth M. Buechler
Associate Counsel
Committee on Veterans Affairs
United States Senate
SR-414 Russell Building
Washington, D.C. 20510

Dear Ms. Buechler:

As a follow-up to your correspondence and our telephone conversation of July 25, 1988, enclosed is the requested information.

If there are any questions, please contact me at FTS 682-5473 or (504) 943-8386. Your interest in Vietnam Veterans issues is appreciated.

Sincerely,

HARRY J. DOUGHTY, MSW

cc: Regional Manager (10B/RC7)
Readjustment Counseling Service

Medical Center Director (00)
V. A. Medical Center
New Orleans, LA

1.

1. In earlier testimony today and in the written testimony of Dr. Matt Friedman, it was noted that there is a relatively low utilization by minorities and women of V. A. sponsored services for PTSD, including Vet Center services.

A. Do you agree with that assessment?

Yes, I agree with Dr. Friedman's assessment.

B. What do you believe can and should be done to encourage minorities and women to use the Vet Centers and other V. A. Health-Care Services?

Before I attempt to answer the specific question, I think it is important to present an historical framework as to why minorities and women underutilize Vet Centers and V. A. Health-Care Services.

First, the Vet Center program and the V.A. Health Care Services, as most social service and health care agencies, are designed primarily from a white middle class perspective. Individuals, regardless of experience and ethnicity, who relate to this perspective will probably interface successfully with these agencies and their personnel. However, the majority of minority veterans come from ethnic perspectives that are not only different from a white middle class perspective, but are also quite frequently in conflict with it. Traditionally, Blacks, as with many other minorities are taught at a very early age to address their problems within the immediate family, extended family or the community. When one leaves those familiar surroundings to seek professional help outside of this community, he is often perceived as being "weak" with an inability to work within an established framework.

For those minority veterans who are willing to go outside of the community for assistance, it is usually for very concrete services such as employment, V.A. and other benefits or financial assistance. It is commonly believed that when Black veterans have taken care of the basic needs of one's family, psychological and emotional problems will subside for the most part.

The National Working Group on Black Vietnam Era Veterans (WG-BV), a Readjustment Counseling Service sponsored group of which I am chairman, reported in its first official paper in 1984 that:

"There is research evidence to support the impression that Black Vietnam veterans show significantly more symptoms of Post Traumatic Stress Disorder (PTSD) than their white counterparts. Only a small percentage of these Black veterans have successfully dealt with their Vietnam experience. It is highly unlikely that any significant number of Black Vietnam veterans will be able to address this issue until their basic social, economic and personal non-psychological needs are met satisfactorily".[1]

Having provided an historical overview, I will now attempt to answer the specific question.

If the Vet Center and V.A. Health Care systems are willing to make the necessary modification in its current approaches to minorities and women veterans, this trend of underutilization of services can be greatly alleviated. Some of the issues and recommendations discussed here were taken from the WG-BV initial paper of 1984. While these recommendations refer specifically to Black veterans, some of these recommendations have applicability to women and other minorities

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[1] Report of the Working Group on Black Vietnam Veterans, The Struggle Continues, 1984.

1. Personnel

The Working Group concluded that there is a need to increase the number of Blacks in decision-making positions at the national (Central Office), Regional, and Team Leader levels.

Recommendations:

1. Active recruitment of qualified Blacks to positions at all levels (i.e., Team Leaders, Counselors, and Office Managers as openings occur) is important, especially in areas where there is a high density of Black Vietnam veterans.

2. To promote and retain current Black Vet Center staff by systematic provisions for special educational scholarship programs that lead toward professional developments in the professional fields of social work, rehabilitation counseling, nursing, psychology, psychiatry, health care planning and hospital administration.

2. Accessibility of existing Vet Center Services to Black Communities.

Vet Center services are to be made more accessible in densely populated Black communities. Such an approach will not only provide greater availability of services to Black veterans, but, at the same time, would eliminate the barriers of social, psychological and geographic distance.

Recommendation:

1. Systematic outstationing of culturally-aware Vet Center Staff in Black communities of high density.

3. Special Educational Assistance Program.

Drawing on the example of nursing scholarships, a program through which the Veterans Administration meets a recognized need for nursing professionals, the Working Group on Black Veterans proposes the establishment of Vet Center scholarships for qualified counselors, who desire to pursue advanced degrees in Social Work, Psychology, Psychiatry, Health Care Planning and Hospital Administration. Like nurses, Vet Center personnel would be required to work within the V.A. or the Federal health care system, for two to four years following graduation, in partial repayment.

An effective scholarship program would enhance the supply of Black Administrative and Mental Health Professionals within the Veterans Administration. The Working Group is aware that the Veterans Administration needs Black Managers and professional service providers. By setting high standards for these scholarship awards, such a program could reverse the trend in which our most able Black personnel are unable to pursue advanced degrees, because of prohibitive costs. Regarded as an investment in the future of the agency (VA), a Scholarship Program of this nature would be remarkably cost effective. This means of attracting and retaining Black Vet Center personnel would provide the agency with a pool of future leaders and would essentially rectify the current situation of so few Blacks in key V.A. positions.

4. Inpatient Post Traumatic Stress Units.

The Working Group on Black Vietnam Veterans holds that Black Vet Center staff can be an asset in the formulation, and implementation of policies regarding inpatient treatment units for PTSD, to include staff patterning and treatment approaches.

Recommendation:

1. Consideration should be given in the location of PTSD units in areas where there is a high concentration of Black veterans.

2. There is a need to actively recruit Black personnel for such units who have demonstrated clinical competence and knowledge in the treatment of post-traumatic stress disorders (PTSD).

5. Outreach.

One of the goals of Operation Outreach (Vet Centers) is to identify and interface with Vietnam veterans in their own communities, especially where minority veterans have not taken advantage of available resources. For the most part, this goal has not been fully realized for Black veterans, due, in part, to inherent restraints in Team composition and limited resources and personnel (usually four members per team). Additionally, the existing methods used to outreach these veterans have been largely unsuccessful due to the reluctance of Black veterans to trust individuals and agencies outside their communities.

There are some who would argue against making additional Vet Center staff available for the express purpose of providing culturally-aware outreach services in the Black community. Though controversial, this outreach approach, has been used in other service settings with good results, since Blacks tend to respond better when the worker and resources are located within his/her communities (e.g., the community mental health centers concept, and other community-based service organizations).

Recommendations:

1. Develop a systematic method of locating and reaching Black Vietnam veterans, which may include the usage of Public Service Announcements (PSA's), pertinent Program literature and other printed materials geared specifically to Black veterans.

2. Increase involvement from the Black community in understanding and meeting the readjustment needs of Black Vietnam veterans. Promote greater sensitivity and awareness to the needs of Black veterans by Vet Center staff.

6. Clinical Issues.

Many Black clients feel that they are scorned by the larger white world, especially within helping agencies. There are many variables which impact upon the client/clinician relationship when attempting to help Blacks in psychological counseling. For example, differing lifestyles, the relative absence of eye-to-eye contact, basic frame of reference in self-disclosure, and verbal fluency in the treatment situation must all be addressed. Thus, the Black Vietnam veteran with PTSD will typically refuse to seek help at traditional agencies, and may be type-cast as "treatment-rejecting" or "untreatable".

Whenever Black clients are involved in therapeutic relationships, there are some important factors which the clinician must address in helping these clients. This is especially true for Black Vietnam veterans. Black veterans do not respond well to abstract therapeutic procedures and often desire tangible results: meeting their immediate needs in the here-and-now. Only later in the treatment process can more abstract, conceptually-oriented, non-directive therapy approaches be employed in a helpful manner. Since few Blacks have had positive encounters with helping agencies and professionals, it becomes incumbent upon the counselor or therapist to exude genuine warmth, regard, and sensitivity, and demonstrated competence in understanding Black culture. Clinicians who overlook these issues will certainly encounter difficulties in working with Black veterans. Working with the Black veteran's spouse is especially crucial to his well-being, according to the Legacies Study.[2] Moreover, it is imperative that relationship dynamics between the vet and his family, and his extended and augmented family members, be considered in the overall treatment plan. The negative stereotyping of Blacks in America has often resulted in low self-esteem, a sense of distrust, alienation, and a feeling of powerlessness. It is incumbent upon clinicians, moreover, to rekindle the veteran's dormant motivation and promote a sense of well-being and self-empowerment.

Recommendations:

1. The clinician is to be trained in a wide-ranging variety of cognitive-behavioral procedures, integrating social therapy, case management, and dynamic-oriented therapy, and must develop adeptness in transcultural treatment modalities (Parson, 1984a).

2. The therapist needs to be clear about his conscious and unconscious fears about blackness and Vietnam, so that as he encourages the veteran to tolerate reality, he does not unwittingly distort the reality of the clients and his needs.

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[2] Legacies of Vietnam, 1981

3. Provide mandatory training to all Operation Outreach staff concerning the special readjustment needs of Black Vietnam veterans and their families, and how to intervene competently (See Parson, 1984 for a tridimensional model of treatment for the Black veteran).

4. Develop methods on how to retain Black Vietnam veterans' involvement until specifically mutually agreed upon treatment goals have been reached.

5. Identify/upgrade and or recruit more qualified Black clinicians.

6. Increase the sensitivity of all staff members to enable them to provide cross-cultural counseling.

7. Learning about Black culture through subscribing to Black magazines, newspapers, and buying books on this area.

8. Seeking supervision from a competent and knowledgeable supervisor with experience in trusting Black veterans (WG-BV-RCS-1984).

2. Do you have any comments on the findings of the R.T.I. study that 471,000 Vietnam Theatre veterans are currently suffering from PTSD?

Yes, briefly, the R.T.I. Study is probably a conservative estimate of Vietnam Theatre veterans who are suffering from PTSD. My comment is based on the number of veterans that I have encountered over the past 15 years from all levels of society and who have often denied that problems do exist. However, their behavior, comments and attitudes clearly indicate that post traumatic stress symptomology or the disorder do exist. However, a great number of these individuals have never been treated.

3. To what extent are your centers, and Vet Centers generally, capable of providing appropriate treatment services for veterans with PTSD? Are there certain levels of severity of PTSD which are and are not appropriate to treat at Vet Centers--and does the capability of Vet Centers vary in this respect?

The New Orleans Vietnam Veteran Resource Center, as many other Vet Centers, is generally capable of providing appropriate treatment services for veterans with PTSD. The extent to which Vet Centers are able to successfully treat PTSD is closely related to the caliber of professionals now in RCS. The current program leadership has actively upgraded Vet Center teams with competent clinicians who are better able to integrate their formal training with that of PTSD assessment & treatment.

I also think there are certain levels of PTSD, as with most maladies, that are not appropriate to treat on an outpatient basis (Vet Centers). There are some veterans who engaged in long-term treatment at the Vet Centers, VAMC and other similar outpatient and inpatient facilities with limited success. There are also some veterans whose PTSD has become unmanageable and extended inpatient care is clearly indicated. In these cases, Vet Centers can be very effective with outpatient after care.

The capability of Vet Centers certainly varies in respect to the treatment of PTSD. For instance, there are some Centers with only one DM&S qualified or other professional team member and there are other Centers where almost the entire counseling staff are DM&S qualified as individuals. Those Centers with only one DM&S

qualified or mental health clinician would probably be limited in effectively treating large numbers of PTSD cases. However, the addition of more DM&S credentialed and other mental health professionals in Vet Centers has improved the capabilities of PTSD assessment and treatment in most locations.

4. Please describe the adequacy of the training you and your staff have been provided to deal with the problems of veterans suffering from both PTSD and substance abuse.

Since RCS's inception, there has been a concerted effort to train all of its team members in the assessment and treatment of PTSD. At lease once annually, each of RCS regional trainings are held with a large portion of training time devoted to PTSD and other clinical issues. In addition to the RCS sponsored training teams are encouraged to participate in VA and other PTSD sponsored training seminars and workshops. A large portion of RCS travel funds are devoted to staff attendance at the annual PTSD conferences such as the National Society for Stress Disorders.

Readjustment Counseling Service has not placed a great deal of time and energy in the area of substance abuse. However, RCS has encouraged team members to work closely with VAMCs and other community programs to ensure Veterans in need of such services are appropriately referred.

The Vietnam Veteran Resource Center concept has resulted in the hiring of team members who have expertise in the treatment of substance abuse at the ten (10) pilot sites.

5. What suggestions do you have for making improvements in the capability of Vet Centers and the VA treatment programs generally to deal with veterans with these dual disabilities?

As the need increases to provide services in substance abuse treatment, I am certain that RCS will continue to monitor these areas and will use its resources accordingly.

The Vet Center members and VAMC personnel need to work in close collaboration and coordinate services in these areas. There should also be conjoint and/or cross training between Vet Center staff and VAMC personnel. Such collaboration and conjoint training allow for greater sharing of resources and a multi-disciplinary approach to treatment planning and aftercare. This approach also allows Vet Center teams members with greater participation in the diagnosis of veterans with PTSD and who have additional problems with drug and alcohol abuse. Similarly, VAMC personnel should gain more insight into PTSD and its assessment and treatment modalities.

A FOLLOW-UP STATEMENT

by

HARRY J. DOUGHTY, MSW

on

AN OVERSIGHT HEARING

on

READJUSTMENT COUNSELING SERVICE

&

POST TRAUMATIC STRESS DISORDER

before

THE SENATE VETERANS AFFAIRS COMMITTEE

on

Thursday, July 14, 1988

Washington, D. C.

Mr. Chairman and members of the Committee - Please allow me to thank each of you for the invitation to present some of my ideas and concerns on readjustment counseling to this distinguished committee.

Personal

I, Harry J. Doughty, have served as Team Leader of the Vet Center (now Vietnam Veterans Resource Center) in New Orleans since November, 1979. Prior to assuming my present position, I served as a social worker and assistant coordinator with the V.A. Medical Center's Drug Dependency Treatment Outpatient Clinic in New Orleans for 5 years.

My 14 years of service with the Veterans Administration have involved working with numerous Vietnam Era and other veterans in one capacity or another. I have also worked briefly as a Food Program Specialist (Quality Control) for the Department of Agriculture's Regional Office in Atlanta. My military service included a tour of duty in Vietnam (1969-70) both as a combat medic and mental hygiene specialist. While on active duty, I was awarded the Combat Medic Badge, 101st Airborne Division. I was also awarded the Bronze Star for Meritorious Service while serving at the 3rd Field Hospital near Saigon.

My stateside duty included 20 months as a social work specialist at Martin Army Hospital, Fort Benning, Georgia.

In addition to holding a Master's Degree in Social Work (1974), I earned a Bachelor's Degree in Pre-Social Work (1968) and an Associate of Arts Degree in the Treatment of Substance Abuse (1978).

My personal experience as a Vietnam veteran and my professional training and experiences have given me the opportunity to successfully interface with numerous Vietnam era veterans, both as a serviceman and civilian.

While attending graduate school, I developed a Vietnam Veterans Outreach Program for Economic Opportunity Atlanta, Inc. (1973). My experience with this program provided firsthand knowledge of problems ex-servicemen were encountering. This experience occurred several years before the Vet Center program was established by Congress; however, the problems presented by veterans at the Vet Center today are similar to the ones which were presented some 15 years earlier. Many veterans, particularly minority veterans, were disillusioned by their military experience and subsequent homecoming. They presented problems with unemployment, lack of marketable skills, drug and alcohol abuse accompanied by feelings of distrust of the system, and a general sense of helplessness. Of course, PTSD was not identified as a problem in the early 70's.

During my tenure as a social worker and later Assistant Coordinator of the VA's outpatient treatment program, I again encountered many young men who appeared to have drug problems that were manifested while on active duty. In retrospect, the use of drugs for these young men was an "undistinguishable cry for help." The cry for help was more related to readjustment problems than the actual abuse of drugs. For many of these men, the Vet Center program came too late to avoid their untimely deaths, incarceration for a number of crimes, mostly violent ones, and other self-destructive behaviors.

Vet Center Overview

The New Orleans Vet Center became operational in April, 1980 as one of the original 91 Vet Centers. From April 1980 through December, 1986, the team has provided services, on an average, to 49 new veterans per month, with approximately 417 monthly visits.

In December, 1986, the New Orleans Vet Center became operational as one of 10 pilot Vietnam Veterans Resource Centers. During the past 18 months (January, 1987 through June, 1988), the New Orleans VVRC has averaged 60 new veterans per month, with an average of 502 monthly visits. In March, 1988, there were 91 new clients seen, surpassing the previous high of 84 new clients attained in February, 1984.

Caseload

While the 20% increase in new clients and in monthly visits are representative of a substantive increase in relation to past years' performance, these figures are not the result of an active outreach component.

Outreach

Although outreach to veterans in their communities is a primary objective of the Readjustment Counseling Service, outreach in New Orleans is virtually non-existent due to the large number of referrals. Referrals to the VVRC are from the Veterans Administration Medical Center, other agencies both public and private, and a large number of veterans who are self-referrals. The New Orleans VVRC, as well as many other Vet Center teams, is finding it increasingly difficult to meet its outreach mission because of limited and strained resources. The lack of outreach effort is critical in many areas of the country in which large number of minority veterans reside.

This limitation in outreach activities in general, and toward minority veterans in particular, is clearly reflected in the recently released report concerning minority veterans, readjustment counseling, and Post Traumatic Stress Disorder (PTSD).

While outreach activities are essential program components, more important still is the issue of the types of presenting problems and the quality of care received once veterans are identified and accept treatment. Of the 60 new veterans seen each month in New Orleans, approximately 49 individuals, or 82%, are Vietnam Era veterans. Of the 82%, approximately 45% are Vietnam combat veterans. Of this 45%, approximately 25 to 40% are suffering from either symptoms of PTSD or the disorder itself. The large variance in percentages is related to a tendency on the part of the Vietnam veteran to deny the existence of the symptoms and/or the disorder and often ask for employment or other services as presenting problems. The incidence of PTSD range from not so severe (outpatient treatment) to very severe (inpatient treatment).

In an effort to better assess the prevalence of PTSD, the New Orleans facility administers a combat related screening packet to all new and active combat veterans, regardless of their era of service. This packet has provided the team with more information during the assessment and treatment planning stages.

A former psychologist on the VVRC staff has proposed to conduct a study that will provide other means of diagnosing PTSD and other psychological problems of combat veterans. This proposed study will also use data from military records as an aid in the assessment of PTSD.

A more thorough assessment of PTSD has become the New Orleans VVRC's top priority. This decision is based on the number and frequency of cases noted in the past five to six months. It is our belief that movies, such as "Platoon" and "Hamburger Hill", and the weekly television series "Tour of Duty", have resulted in a larger number of new veterans being seen and diagnosed monthly.

VVRC/VAMC Collaboration.

Of course, with improved assessment techniques and more diagnosed cases, it is imperative that close collaboration and coordination of services exist between the local center and the mental health professionals within the VA support facility.

While the New Orleans VVRC staff has worked closely with most of the mental health professionals at the VAMC, there is an ongoing need to monitor the effectiveness of PTSD assessment, the mutual referral process, and aftercare at both facilities.

The monitoring of these areas is critical in New Orleans as in many other locations across the country because of the limited amount of acute inpatient psychiatry beds and the lack of an inpatient stress recovery unit within 400 miles.

Traditionally, the majority of PTSD diagnosed cases in New Orleans have been successfully followed on an outpatient basis. However, in many cases, inpatient stress recovery is clearly indicated.

PTSD Treatment and Stress Recovery Units

In an effort to refer some of the veterans out of state, there has been a tendency for most of these veterans not to be admitted to these units for a number of reasons.

The first is that most of the units have long waiting lists and veterans who live in the general vicinity of these units are usually given priority for admission.

Second, many veterans are not willing to leave their families, the security of familiar surroundings, and perhaps employment, for extended periods of time.

Third, when a veteran is invited for pre-admission screening, there is no guarantee that he will be accepted into the program, and the trip is at his own expense which may also result in several days of lost wages.

Given these obstacles, the VVRC staff remains committed to facilitating the admission of certain PTSD cases for inpatient care.

This is especially true of veterans who have engaged in long term treatment at the VVRC, the VAMC, and other similar outpatient and inpatient facilities with limited success.

For those veterans not in need of inpatient treatment, the New Orleans staff has been highly successful in providing treatment on an outpatient basis. The treatment provided may be in the form of individual, group, couples and family counseling, depending on the severity of the case and the needs of the veterans and their significant others in any stage of the treatment process.

Generally, these veterans are asked to commit themselves to the treatment process for nine (9) months or longer. Experience has shown that most veterans who terminate the treatment process in periods less than nine (9) months tend not to have a satisfactory recovery. When veterans have committed themselves to long term treatment, the disorder may go into remission; however, veterans have been known to return for further treatment when there have been significant changes in their lives.

Returning to treatment should not be viewed negatively. More important than the veteran's relapse is the availability of readjustment counseling services when needed.

Drug/Alcohol Screening, Referrals, and Follow-up

The VVRC, with its drug/alcohol component, is now better able to work with those veterans who are diagnosed with PTSD and also with a history of drug and alcohol abuse/addiction. These veterans, for the most part, are now followed by a VVRC staff member at the time of admission, during treatment, and after discharge. The VVRC team members work closely with both the in-patient drug and alcohol units through consultations with staff and veterans.

Upon discharge, those veterans who are in need of other readjustment counseling services are referred to the VVRC for drug relapse prevention and AA support. Treatment approaches are now more comprehensive and at the same time allow for closer collaboration and follow-up for drug dependent veterans who are discharged from the VAMC's inpatient alcohol and drug units and referred to the VVRC.

Minority Veterans and Readjustment Counseling

Traditionally, Black people in general are taught at a very early age to address their problems within the immediate family, extended family, or the community. When one leaves those familiar surroundings to seek help outside of his community, he is often perceived as "weak" with an inability to work with an established framework.

For those veterans who are willing to go outside of the community for assistance, it is usually for very concrete services such as employment, VA benefits, or financial assistance. It is commonly believed that when Black veterans have taken care of the basic needs of one's family, psychological and emotional problems will subside for the most part. If these emotional and/or psychological problems persist, then the community is expected to rally around these problems.

Perhaps the one exception to this cultural upbringing and the handling of problems is in the area of drug/alcohol abuse. While it is recognized that substance abuse is self-destructive, it is often tolerated in the Black community. This toleration of substance abuse is closely related in part to the plight of Black men in this country and sometimes is viewed as a part of the therapeutic process (Black man's psychiatrist).

Since drug/alcohol abuse is foreign to Blacks in general, prior to the introduction of such substances in their community, the need to go outside of the community for help is acceptable.

Going outside of the community removes some of the social stigmas for family members, allows for a certain amount of confidentiality, and addresses a problem the Black community has little, if any, history in understanding or addressing.

Minority Veterans and Readjustment Counseling Service.

Readjustment issues of minority veterans remain almost as controversial as the war and some current treatment approaches of those working with Vietnam veterans. Minority veterans have become an almost forgotten piece of the Vietnam veteran experience, especially as they interface with the Veterans Administration and Readjustment Counseling Service.

Since 1983, Readjustment Counseling Service has attempted to address unique issues of Blacks and other minority veterans through special population working groups. Over the past five years, the Working Group for Black Vietnam Veterans (WG-BV) has made some positive gains in sensitizing others to the unique readjustment needs of this population.

Despite RCS's intent, Black veterans still tend to underutilize Vet Center services for their readjustment issues.

The recent preliminary report released by the Research Triangle Institute revealed that 19% of Black Vietnam veterans suffer from PTSD but have never been treated. Similar figures are found among other minorities; for example, 30% of Hispanic Vietnam veterans in the survey suffer from PTSD and have not been treated for this condition. While these percentages are alarming, they are consistent with my belief that most minority veterans do not engage in treatment addressing their psychological and emotional problems. While on the surface it may appear that these veterans are not motivated to seek treatment, their hesitancy is more related to culturation rather than a lack of motivation. If the preliminary report on minority veterans mentioned above is accurate, assessment and treatment of PTSD becomes more problematic.

Historically, many minority veterans have not initially presented PTSD related symptomatology during early visits. Therefore, team members must spend many hours over a long period with these veterans before an identifiable pattern of psychological problems begins to emerge. When initially working with minority veterans, it is imperative that this extended period of time be allowed in order to work through the presenting problem. As the goal of treatment is to address the underlying psychological problem, an assessment which might normally be completed in 6 hours with some veterans may take as long as 15 hours with minority veterans. Experience has shown that a therapist who attempts to accelerate this process will probably lose the client after one or two visits.

In order to increase the number of Black veteran's involvement in RCS in any meaningful manner, the following must occur:

1. The current outreach approaches must be modified to actively go into areas where Black veterans congregate.

2. The White middle class orientation of treatment modalities of Vet Centers should be modified to address unique issues of Black veterans.

3. The current′resources available through Vet Centers should be modified to include meaningful education, training opportunities, and extension of VA Benefits, particularly for college bound veterans.

4. The outstationing of Vet Center Counselors in the Black community on a weekly basis.

5. An education program that will not only address issues of Vietnam with veterans, but their family members as well.

6. Research efforts for Black veterans have been almost non-existent. There has to be a viable research design that will provide more data on the plight of these veterans.

7. Vet Center team members need more flexibility to explain problems of Black vets through professional writings and publications.

Vietnam Veteran Resource Center (VVRC) Update

Since the designation as a Vietnam Veterans Resource Center, the New Orleans facility has enjoyed unparalleled success. The addition of two full-time employees has provided additional support and flexibility in meeting the mission of Readjustment Counseling Service.

The addition of another social worker to the staff has allowed for increased community involvement in a number of areas. One such area is in the area of training of MSW interns. The two full-time social workers on staff present the opportunity for three MSW interns from two schools of social work to complete their field placement at the VVRC.

With the addition of a full-time administrative assistant, the Team Leader is now able to interface on a more frequent basis with various services at the VAMC and other Veteran and community leaders.

The presence of two full-time Disabled Veteran Outreach Program Specialists (DVOP's) has allowed more services in employment and related areas. As you are probably aware, Louisiana has led the nation in unemployment figures most of 1987 and 1988. Despite the sagging economy in Louisiana, the DVOP's have been very effective in working with the public and private sectors in placing a significant number of veterans in meaningful employment. One of the DVOP's assigned to the VVRC was honored by the Department of Labor as the number one DVOP in the state of Louisiana in 1987.

One major deficit in services provided by the VVRC is in the area of Veterans' benefits counseling. At the present time, there is no in-house VA benefits counseling for veterans in need of such services provided by the Department of Veterans' Benefits. Because of this is void, veterans in need are routinely referred to either the VA Regional Office or other Veterans' Service Organizations.

Other Readjustment Issues

While RCS has an exemplary record in addressing the readjustment problems of a significant number of Vietnam-era veterans, there is a need to expand the number of sites to include underserved areas as was recently accomplished in the states of Hawaii and West Virginia.

Evidence of Need

A needs assessment in Louisiana and Texas revealed that there are approximately 141,000 Vietnam-era veterans living in the area between New Orleans and Houston. At the present time, there is only one contractor to provide readjustment counseling services to these veterans. Recent meetings with veterans' organizations' leaders have revealed that Vietnam Era veterans in this area continue to suffer severe problems.

Veterans in this area, if not seen by the contractor, must travel more than 150 miles either toward Houston or New Orleans for readjustment counseling. If, in fact, meaningful services are to be provided, veterans should not have to travel such distances one or two times a week.

To counteract this void in services, the New Orleans VVRC has recently identified a contractor who will be able to provide services to approximately 14,000 veterans in East and West Baton Rouge parishes. The VVRC will continue to aggressively solicit additional providers in outlying areas.

It should be noted that a reprogramming of Fee Contract dollars into Vet Center personnel would result in a great savings which would also permit greater RCS control over the quality of Services.

While Louisiana and Texas are discussed here, I am certain that similar situations exist in many other parts of the country.

Conclusions/Recommendations.

The successful efforts of Readjustment Counseling Service have resulted, in part, because of a strong commitment from RCS officials, team members, and concerned individuals and organizations within the veterans' community. However, if RCS is to continue to be successful in its mission as an innovative and cost-effective component of the VA, a number of changes are clearly indicated in addition to those previously discussed.

1. Outreach: Current outreach approaches must be modified to allow Vet Center team members to work with veterans in their communities. This area is especially critical concerning minority veterans.

2. PTSD Assessment and Treatment: Vet Center team members must continue to improve their skills and knowledge of PTSD and other psychological problems through appropriate workshops and seminars. Ideally, in order to enhance the collaborative efforts of VA personnel, more joint and/or co-training opportunities should be afforded for both VAMC and Vet Center personnel.

3. PTSD Treatment and Specialized Units: The increase in diagnosis of PTSD according to DSMIII-R will undoubtedly result in more referrals to in-patient stress units. If the needs of these veterans are to be adequately addressed, it will be necessary to expand the number of these specialized units into more strategic locations throughout the country. The presence of a Stress Recovery Unit in New Orleans would eliminate the need for veterans to travel more than 800 miles round trip for treatment lasting extended periods of time. If additional units are established, there must be conjoint and/or cross training and collaboration between Vet Center staff and VAMC personnel staffing these units.

4. VAMC/Vet Center Collaboration: The current level of VAMC/Vet Center collaboration should at least continue. Such collaboration allows for greater sharing of resources and a multi-disciplinary approach to treatment planning and aftercare. This approach also allows Vet Center staff greater participation in the diagnosis of veterans with PTSD and who have additional problems with drug and alcohol abuse.

Finally, Mr. Chairman, the success of Readjustment Counseling Services for Vietnam Era veterans and perhaps veterans of other eras will depend in a large part not only upon the commitment of those individuals employed by Readjustment Counseling Service, but also on the commitment from all levels of our society.

There must be an ongoing commitment by staff in expanding their expertise in providing readjustment counseling services to veterans as well as a commitment of all available resources. Considering fiscal reductions in many Federal programs, the Veterans Outreach Program should not become another "bad" memory for our nation's Vietnam veterans.

The healing process which began in 1979 should continue, and just as our nation committed its resources for its men to fight and become veterans, similar resources must be put in place so that these veterans may enjoy their well earned status just as their fathers and grandfathers enjoyed following previous wars.

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO

OBED FERNANDEZ AND THE RESPONSES

1. STATEMENT OF EXPERIENCE AND TENURE IN THE VET CENTER PROGRAM.

As a Vet Center Team Leader, I Obed Fernandez, M.S.W., came with a DM&S qualified educational background. I received a Master's Degree in June of 1975 from California State University, Fresno. During my military service as a Medical Corpman with the 7th Battalion 8th Artillery II Field Force in Vietnam 1970-71, I developed an interest in health and human services.

My experience includes: Child Protective Services, San Bernandino County; Ramona Drop in Center; Mayor Holcombs staff, city of San Bernadino; Psychiatric Inpatient Services, Fresno County; Crisis Services, Fresno County; Big Brother/Big Sisters, Fresno, CA; and VAMC Long Beach and VAMC Fresno as a Medical Social Worker.

I am a SWALT (Social Work Administration and Leadership Training)graduate. A VAMC Administrative program to prepare for as Chief of Service. I came to the Vet Center Program in August of 1987 following 13 years experience with the Veterans Administration Medical Centers.

Having the first hand experience in the Medical Centers I believe enhances my abilities in getting things done as a Team Leader. Being a Vietnam veteran allows me to be empathetic with my clients especially those who have difficulty with Trust. A distint advantage I have is that Medical Corpman earned the respect of the soldiers wherever they were in Vietnam.

Since my return from Vietnam my education has never stopped. I have successfully completed numerous course in both the clinical and administrative areas.

As Team Leader I now provide counseling for individuals, couples, families and groups. The Vet Center Program has an excellent education program. On a yearly basis, Team Leaders meet to receive both clinical and administrative training. This is also provided for the counselors and office managers. In addition the Medical Centers provide training which we attend. We also contract with consultants for staffing cases and training in areas of staff needs (i.e., DMS III-R, How to form groups, and assessments). All staff are encouraged to attend university courses as their personal time allows.

2. IN EARLIER TESTIMONY TODAY AND IN THE WRITTEN TESTIMONY OF DR. MATT FRIEDMAN, IT WAS NOTED THAT THERE IS A RELATIVELY LOW UTILIZATION BY MINORITIES AND WOMEN OF V.A. SPONSORED SERVICES FOR P.T.S.D., INCLUDING VET CENTER SERVICES.

A. DO YOU AGREE WITH THAT ASSESSMENT?

I agree with the assessment.

SENATE OVERSIGHT HEARING QUESTIONS
OBED FERNANDEZ, Vet Center#628
Fresno, California

B. WHAT DO YOU BELIEVE CAN AND SHOULD BE DONE TO ENCOURAGE MINORITIES AND WOMEN TO USE THE VET CENTERS AND OTHER V.A. HEALTH-CARE SERVICES?

One thing I have noticed since my employment at the Vet Center in August 1987 my being hispanic has I believe opened the door for many hispanic veterans. I believe that an empahsis should continue to be stressed that Vet Center staff attempt to have both minorities and women on their clinical staff. I think Vet Centers can begin by removing items (pictures, decals, etc.) from the premises which give the message "men only." Or include photos and/or posters of women for a balance. Outreach to specific organizations that focus on women and minority issues should also be tapped.

3. DO YOU HAVE ANY COMMENTS ON THE FINDINGS OF THE R.T.I. STUDY THAT 471,000 VIETNAM THEATRE VETERANS ARE CURRENTLY SUFFERING FROM P.T.S.D.?

I am truly impressed both by the depth and the quantity of their research. The numbers alone lend to its validity.

4. TO WHAT EXTENT ARE YOUR CENTERS, AND VET CENTERS GENERALLY, CAPABLE OF PROVIDING APPROPRIATE TREATMENT SERVIES FOR VETERANS WITH P.T.S.D? WHICH ARE AND ARE NOT APPROPRIATE TO TREAT AT VET CENTERS --AND DOES THE CAPABILITY OF VET CENTERS VARY IN THIS RESPECT?

This Vet Center, Fresno, I believe has excellent capabilities of treating P.T.S.D., as described by the DSM III-R. I believe Vet Centers can and do evaluate and assess situations that are better handled in a hospital setting. These generally are with regard to substance abuse, alcohol abuse, and personality character disorders.

P.T.S.D. on its own can be treated by Vet Centers. When we encounter P.T.S.D. with other diagnosis and they are out of control we can and do arrange for appropriate services, both in the community and VAMC.

Vet Center staff recognize and can assess when a person is a danger to himself/herself or others or is gravely disabled. These cases will be referred/transferred or taken to appropriate levels of care for further evaluation and treatment.

5. A. PLEASE DESCRIBE THE ADEQUACY OF THE TRAINING YOU AND YOUR STAFF HAVE BEEN PROVIDED TO DEAL WITH THE PROBLEMS OF VETERANS SUFFERING FROM BOTH P.T.S.D. AND SUBSTANCE ABUSE.

SENATE OVERSIGHT HEARING QUESTIONS
OBED FERNANDEZ, Vet Center#628
Fresno, California

Our staff is well prepared to deal with P.T.S.D. We are also able to assess substance abuse and alcohol problems. One of our staff members, Steve Giles, a Vietnam veteran with a Purple Heart who is service connected, has several years of experience working with substance abuse and alcohol problems. When we assess these problems we staff the case and get treatment for those problems first and then provide supportive care and after care for those veterans.

B. WHAT SUGGESTIONS DO YOU HAVE FOR MAKING IMPROVEMENTS IN CAPABILITY OF VET CENTERS AND OF V.A. TREATMENT PROGRAMS GENERALLY TO DEAL WITH VETERANS WITH THESE DUAL DISABILITIES?

Utilize the priority treatment for P.T.S.D. to its fullest. Educate the Medical Staff at V.A.M.C. to sensative to these issues. Continue the collaboration with both the V.A.M.C. and its treatment facilities and the private care programs in the community. Team Leaders who can attend meetings at the V.A.M.C. to enhance the delivery of services. Consider giving DM &S qualified clinicians admitting priveledges with V.A.M.C.s.

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO

BOB MEREDITH AND THE RESPONSES

Q: IT WAS NOTED THAT THERE IS A RELATIVELY LOW UTILIZATION BY MINORITIES AND WOMEN OF V.A. - SPONSORED SERVICES FOR P.T.S.D., INCLUDING VET CENTER SERVICES.

Q: DO YOU AGREE WITH THAT ASSESSMENT?

A: Yes, there is a low usage by these veterans.

Q: WHAT DO YOU BELIEVE CAN AND SHOULD BE DONE TO ENCOURAGE MINORITIES AND WOMEN TO USE THE VET CENTERS AND OTHER V.A. HEALTH-CARE SERVICES?

A: -- Outreach is one of the keys to making our service available.

--Requiring Vet Centers to create an atmosphere or decor that may be more conducive to the group you are trying to reach.

--Encourage or require personnel at Vet Centers to become more acquainted with the cultural and special problems of the minority group in question. More sensitivity to the group's position and culture is a must.

Q: DO YOU HAVE ANY COMMENTS ON THE FINDINGS OF THE R.T.I. STUDY THAT 471,000 VIETNAM THEATRE VETERANS ARE CURRENTLY SUFFERING FROM P.T.S.D.?

A: I believe this figure to be quite low. There are many degrees of P.T.S.D. and to quote an exact figure of 471,000 sounds unequvocal and final. Millions of men and women served in Vietnam during the course of the war. It seems difficult, at best, to quote any figure and especially a low amount.

Q: TO WHAT EXTENT ARE YOUR CENTERS, AND VET CENTERS GENERALLY, CAPABLE OF PROVIDING APPROPRIATE TREATMENT SERVICES FOR VETERANS WITH P.T.S.D.? ARE THERE CERTAIN LEVELS OF SEVERITY OF P.T.S.D. WHICH ARE AND ARE NOT APPROPRIATE TO TREAT AT VET CENTERS -- AND DOES THE CAPABILITY OF VET CENTERS VARY IN THIS RESPECT?

A: The treatment of P.T.S.D. varies in severity from one case to another, therefore, the staff members must be prepared to work with the most severe case of P.T.S.D.

There have been many cases at our Centers where we have encountered multiple diagnosis of problems, i.e. substance abuse and P.T.S.D., where a referral was imperative to the ultimate care of the client.

Vet Centers do vary in their abilities to care for clients who suffer from this multiplicity of problems. There are many specalized fields of expertise and our client's problems fall within this range.

Q: PLEASE DESCRIBE THE ADEQUACY OF THE TRAINING YOU AND YOUR STAFF HAVE BEEN PROVIDED TO DEAL WITH THE PROBLEMS OF VETERANS SUFFERING FROM BOTH P.T.S.D. AND SUBSTANCE ABUSE.

A: We are provided with a wide range of training activities during the course of a year. Once a year our region holds an annual training week. During this week, a variety of courses are offered both in substance abuse and P.T.S.D. problem areas.

We are encouraged to attend courses that will enhance our ability to work with P.T.S.D. and substance abuse cases, on a time available and money available basis.

Q: WHAT SUGGESTIONS DO YOU HAVE FOR MAKING IMPROVEMENTS IN THE CAPABILITY OF VET CENTERS AND OF V.A. TREATMENT PROGRAMS GENERALLY TO DEAL WITH VETERANS WITH THESE DUAL DISABILITIES?

A: It is necessary to hold workshops and in-service trainings about our respective programs. This type of training would allow both facilities to begin to understand how the other operates.

Working together means learning what the other is offering. A possible way to improve the capability of providing services would be to combine therapists from each of the facilities to co-facilitate groups. Each would be capable of identifying symptoms they are familiar with.

Outward Bound

Hurricane Island
Outward Bound School
P.O. Box 429, Mechanic St.
Rockland, Maine 04841
Telephone 207-594-5548

July 18, 1988

The Honorable Alan Cranston
Chairman, Committee on Veterans Affairs
United States Senate
Room 414, Russell Senate Office Building
Washington, DC 20510

Dear Senator Cranston:

Thank you for the opportunity to testify before your committee on July 14th. It was a privilege to be included among the group of distinguished witnesses you gathered for the hearing, and I salute you and your fellow committee members for your continued interest and efforts on behalf of America's veterans.

I enclose responses to the written questions you presented me at the conclusion of my testimony.

Sincerely yours,

Robert B. Rheault
Program Director
Vietnam Veterans Program

RBR:cay

Enclosure

Q:
1. You have been operating an Outward Bound program in conjunction with the specialized PTSD unit at Northampton, recently started one at American Lake, and are about to start one at Augusta for the VA.

A. Do you have plans to implement the program at any other facilities?

B. If the VA were to fund the Outward Bound program as a pilot program, would your organization be capable of expanding so that the program could be available to at least half of the VA's 13 specialized inpatient units?

A:
1. A. The implementation of additional Outward Bound programs in support of more PTSD units is dependent on funding. I have met with the staff of the Togus, Maine unit; and we plan to start a program there in May of 1989. In the meantime, I am working to raise money to fund this.

Also, with the help of the Paralyzed Veterans of America, we have a proposal under consideration by the Agent Orange Assistance Fund. If this proposal is approved, we intend to start up a program at either Phoenix, Arizona or Menlo Park, California.

B. With the experience we have gained and are gaining at Northampton, MA, Tacoma, WA, and Augusta, GA and the involvement of three of the five Outward Bound schools, it would not be difficult to expand to support a total of 6 or 7 PTSD units. Two factors should influence the selection of the next units to be selected: one, readiness and willingness of the PTSD unit staff to participate; and two, proximity of the PTSD unit to an appropriate wilderness area.

Q:
2. A. Do you have any data to demonstrate that the veterans who have participated in your program need less hospitalization or have fewer relapses of PTSD symptoms than those who do not participate in your program?

B. Do you believe that such a final scientific research project should be carried out?

A:

2. A. Due to a lack of funds to pay for a research project, we do not have any quantifiable data at this time. We do have a great deal of testimony from both clinicians and veterans themselves who believe that the Outward Bound program was of major positive value in their recovery. Some of this was provided as a part of the written testimony provided to the committee.

Funds provided this year by the Paralyzed Veterans of America have permitted the initiation of a research project.

B. I believe that a research project would be of value; however, it should be pointed out that the various PTSD units vary widely in technique, length of stay and quality and it will be difficult to measure results against this imprecise background.

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO DR. RAYMOND SCURFIELD AND THE RESPONSES

Medical Center

American Lake
Tacoma WA 98493

Veterans
Administration

26 July 1988

In Reply Refer To: 505/116A

Senator Alan Cranston, Chairman
Committee on Veterans' Affairs
Washington, D.C. 20510-6375

Dear Senator Cranston:

Thank you for your feedback regarding my testimony at the Oversight Hearing held on July 14, 1988, regarding PTSD and the Veterans Administration. In response to your request in your July 21, 1988 letter, I will now address the five follow-up questions that you have asked me to respond to in writing.

Question #1:
"On page 5 of your testimony, in addressing areas with no availability of PTSD resources, you state: "Thus, we have had to provide "earlier level" stress recovery interventions with this sub-group of veterans, as appropriate resources simply do not exist in many geographic areas." Would you please explain what you mean by "earlier level stress recovery interventions"?

Response:
As stated in my testimony, we do admit some isolated veterans who have had little prior PTSD treatment available to them. Such veterans do require more attention to several "earlier-level" stress interventions (than do veterans with significant prior PTSD treatment experience): (1) establishment of the therapeutic trust relationship; (2) education regarding the stress recovery process; (3) teaching various stress reduction, anger and sleep disturbance symptom-control techniques; (4) grounding in a peer-group treatment and therapeutic community milieu; and (5) fear and other significant reactions in response to (a) hearing very emotional details from other veterans about their traumatic war-related experiences, and (b) sharing one's own beginning discussion of traumatic war-related experiences.

While all five of these factors are inherent PTSD treatment principles and must be attended to with every veteran who is admitted to this program, these are "earlier level" stress recovery interventions that the more isolated veterans may have had relatively little experience with and hence require more attention in these areas by peers and staff. As a point of reference, later-level interventions would include: significant in-depth exploration of various war-trauma and civilian readjustment experiences, being able to place the war-experiences into a "whole-life" perspective that includes understanding important pre-military and post-military factors along with the war-trauma, and integrating various positive and negative factors about the war-experiences into one's identity and where one is going with one's life. (A two-page hand-out on "Post-Traumatic Stress Treatment Principles" is attached for your reference).

Question #2:
On page 6 of your testimony, you state that 47% of the questionnaires were returned completed. Do you believe that those veterans who did not benefit from the treatment would be less or more likely to return the questionnaires completed than those who did so benefit?

Response:
This is a difficult question to answer at this time with any degree of certainty; there are reasons to support either argument. Veterans who did not benefit as much as others might not respond as frequently because (a) they might have negative feelings about our program and not want to answer anything; and (b) veterans with low-benefit may be overrepresented among transient, homeless or very mobile veterans who actually did not receive the questionnaires in the first place.

On the other hand, veterans who did not benefit as much might respond more frequently because (a) this is their chance to "tell us what a lousy job we did" (e.g., it would be very easy to return an incomplete or blank questionnaire to us in the self-addressed, stamped envelope with no comment or a brief negative comment (two out of 180 veterans did so); and (b) they may be hopeful of returning to the program because they realize that they need more help, and they may think that answering the questionnaire will increase their chances of being readmitted at a later date.

There are some research strategies that we are pursuing to determine how similar or different the "response" vs. "no-response" groups are; if similar, then the assumption is that the two groups also would have similarly benefited (or not) from the program and responded similarly. The measures obtained on all veterans that will give us some indication about similarities and differences include: (1) their discharge diagnoses upon leaving the program; and (2) their pre-treatment measures on Impact of Events Scale, Mississippi Scale for Combat-Related PTSD, and a symptom-checklist constructed by our program. We have not been able to complete such comparisons yet, and hope to have such within about a month.

In conclusion, with the data now available to us, we are assuming that the 47% who returned questionnares are representative of at least 90% of the entire pool of graduates -- with the possible exception of an overrepresentation among non-respondents at the extreme end of the continuum (10%) who may be doing so poorly that they wouldn't or couldn't return the completed questionnaires.

Question #3:
Please comment on the effectiveness of the Outward Bound wilderness experience, in general, and specifically comment on its effectiveness in promoting group bonding.

Response:
This question encompasses what we currently are in the process of objectively assessing about the Outward Bound experience through a $50,000 grant through Paralyzed Veterans of America, and which will be replicated by the Augusta VAMC PTSD unit in a collaborative research effort with us. We have completed three-

day and four-day courses with two groups of inpatients, a six-day course with program graduates (outpatients), a four-day course with Vet Center clients (who had not been inpatients), and about 10 (one-day "rope and height challenge") courses with 10 different groups of inpatients. Based upon these experiences, we are particularly impressed with the impact of the several-day overnight courses conducted in conjunction with inpatient PTSD treatment in our 11-week program. Individual improvement (oftentimes of a dramatic nature) has been observed typically in one or more areas: improved self-esteem, reducing fear and rage, increasing one's sense of competence and mastery over the environment, increasing the ability and perception that life can be enjoyable once again, the ability to take aspects of the experience, (i.e., the metaphor of navigating the river and obstacles in it) and apply such to everyday life, improved sleep patterns, greater acceptance of the realities of physical disabilities (both limitations of and ability to transcend to some degree), and facilitating therapeutic work on specific war-related trauma that were triggered by the Outward Bound experience (i.e., a capsized raft bringing back a tragedy that occurred on the river in Vietnam). Finally, as far as impact on the group as a whole, there appears to be (1) significantly increased bonding, cohesion, and ability and willingness to honestly confront and support each other during the program, as well as (b) significantly reduced conflict and animosity towards the staff.

However, these are clinical observations. What we don't know through systematic measures are the extent of and how long such positive impacts last, and how this compares to vets who go through the program but do not have the Outward Bound experience -- our research project is designed to look at such questions. At this time we do have some initial concerns about the Outward Bound experience with outpatients, particularly those not currently clinically involved -- there has been a problem in getting such veterans together after the trip in order to conduct adequate debriefings, for example. Such problems do not appear insurmountable, but do require revised expectations and careful planning to prevent or minimize problems. Bob Rheault's submitted testimony does include as an attachment, a detailed descriptive evaluation of our experience last year with Outward Bound that I wrote. Overall, the approximately $150 per day per vet cost for a four-day course appears to be money extremely well-spent and provides results really not achieveable through regular inpatient-type activities.

Question #4:
What are the clinical benefits, if any, derived from the use of the 3-day assessment period and the shortening of the length of stay?

Response:
Three-day assessment: The three-day short-stay assessment and orientation component of the program was instituted for both clinical and reimbursement purposes. The clinical benefits include: (1) the veteran is provided an opportunity to really "check-out" the program personally, talk to current inpatients without staff around, begin relationship-building with some of the staff, and sit in on several of the psycho-educational class activities (such as anger control, stress management, etc.); (2) the staff have the opportunity to check out the veteran in person: appropriateness, motivation and readiness for intensive longer-term inpatient treatment. This is in addition to data provided on the written application that had already been submitted both by the veteran and the referral source (what is written on the application may or may not be entirely accurate or may be misleading). (3)

staff can make timely decisions regarding what continued or additional treatment may be indicated until admission to the 11-week component, i.e., to complete a substance abuse treatment program, or participate more in peer-group treatment. We find that such "conditions" maximize what veterans can get out of the 11-week program. Because of our cohort (group) admission policy, and our extensive waiting list (over 150 veterans and 9 - 10 months' wait), there are two additional factors: (4) our 24 intensive inpatient beds literally are precious resources and the 3-day stay helps us to maximize their utilization; and (5) the 3-day admission provides an "in-between" assessment and clinical contact with the veterans (during the 9 - 10 months from date of receipt of written application to entry into the 11-week component). We believe this interim, significant clinical contact is required by us in order to make sure that the veterans literally are not simply "waiting", languishing or deteriorating during the lengthy waiting period. Finally, over a several month period of time it may become apparent that other treatment rather than our program will suffice, or is necessary, such as intensive outpatient or acute inpatient psychiatric treatment.

Shortening the length of stay (LOS):

To a large extent, the length of stay (LOS) per se cannot be looked at as a singular factor; however, it is our conviction that it is unrealistic to have significant and enduring therapeutic impact on the veteran population that we treat in less than about 10 weeks, under ideal resource conditions. Realistically, one must consider several factors in conjunction with determining a necessary LOS (1) the number and quality of staff, foremost; (2) the range and functions the staff perform; (3) the type of admission (cohort or group vs. serial); (4) the treatment approaches utilized; (5) the chronicity, severity and multiplicity of presenting problems that will be significantly addressed during the inpatient stay; and (6) the amount of pre-bed and after-care therapeutic in-puts that are required or provided. We strongly believe that several such factors about our program allow for maximal benefit within a 10-12 week LOS: requiring applicants to be in a current outpatient relationship; cohort (vs. serial) admissions; 60% war-zone veteran staff and qualified non-vet staff; peer group treatment and therapeutic milieu emphasis; a knowledgeable biologic (psychiatric) component; emphasis on the provision of chronic PTSD and associated conditions (vs. acute treatment); and providing selected pre-bed and after-care services in close collaboration with community-based resources.

We have operated with 14, 13 and 11 week lengths of stay, and with admitting from 10 to 13 veterans in each admission class. Our impression considering current resources, is that an ideal uninterrupted LOS for many of the admitted veterans is about 12 weeks and about 12 veterans in each class; there would still be a substantial sub-group (perhaps over 25%) who could utilize a longer LOS. However, there are additional factors that lead us to consider the 12 week stay as the best choice considering available resources: (1) with our huge waiting list, anything we do to decrease the number of veterans we treat will automatically increase the size and length of the waiting list; therefore, we must continually balance between providing quality services to the maximal number of veterans but not reduce the quality of treatment provided below a certain level; (2) we believe that there is a point of diminishing return in terms of an uninterrupted LOS going beyond a certain point, e.g., beyond a certain LOS may (a) promote institutionalization and over-dependency on the program, and not allow the veterans to have substantial real-world experiences (e.g., outside of the hospital) in which to realistically test and integrate learnings gained from inpatient hospitalization; and (b) a number of the veterans actually become "saturated" during their inpatient stay with war-trauma and other psychological issues, to the point where additional therapeutic inputs may not be adequately received by the veteran at that time.

On the other hand, reducing the LOS below 10 or 11 weeks (without also reducing the number of veterans being treated in each admission class) will result in surface-impact only and a revolving door phenomenon characterized by "starting over again" each time. For the 25% or so of admitted veterans who actually require more than 10 - 12 weeks, we believe that it is better to complete the targeted 11-week or so LOS, go into the real world for six months to one year (with proper after-care) and then return to go through the program a second time. Going through the entire program a second time may seem to be redundant, but our experience is that a number of admitted veterans simply do not retain all or even most that is provided to them the first time through; this is a result of mistrust, fear, numbing, still "drying out" physiologically and psychologically from substance abuse, or because the veterans have so many problems to deal with, etc.

If restricted [illegible] and [illegible] clinical needs were not taken into consideration, we would probably implement the following: 10 veterans admitted into each class, for a 12-week LOS; readmit 25% or so within six to twelve months for a second 12-week LOS; and probably then readmit about 10% for a third 12-week LOS within another six to twelve months. We would utilize any additional resources to cycle more than two cohort groups through the program at any one time (which is our current capacity).

Question #5:
In your testimony you stated that "We discovered after the first year of operation, that our assumption that we could devote little effort to outpatient after-care treatment, was incorrect." Please elaborate on this discovery and tell how aftercare is now handled at your facility.

Response:
My statement in the testimony following the above quoted sentence does elaborate on the critical factors that were involved in increasing our outpatient (follow-up) services, e.g., "...some of the inpatient gains made might be temporary if the veterans did not rather quickly become engaged in after-care treatment with someone...to consolidate gains made, deal with issues for which there was not sufficient time to attend to ...additional issues that arose following discharge...familial, employment, substance abuse...a number of our graduates preferred to obtain their aftercare from our staff...and some aftercare resources were only capable of providing early-level PTSD interventions..."

I might add that many of the PTSD-knowledgeable referrors (Vet Centers, fee-contractors and VAMCs) seem so busy with the clinical demands facing them that to adequately deal with the later-levels of stress recovery of our graduates is somewhat problematic due to referrors being overloaded to begin with and/or not geared to providing such. Also, we are convinced that it is most important that program graduates get into regular after-care with someone who can be helpful; we thus transcend any "turf" issues with other referrors and simply assist our graduates to get connected in aftercare with whomever they believe can be helpful. We also have found that a number of our graduates who require some psychiatric medications (and comprise about 16% of our outpatient visits) are not at all comfortable with most other psychiatrists anywhere outside of our program. Finally, being active in after-care keeps us in touch with the realities of life after our program, and has a profound impact on our understanding of the results of going through treatment in our program and allowing us to make adjustments. I cannot overemphasize the importance of such a reality-based clinical feedback loop, which also optimizes our understanding of what aftercare type of resources to encourage our veterans to engage with. Many intensive inpatient programs inherently are isolated from the realities of the real world; by expecting our staff to do both inpatient and selective aftercare services, we literally cannot remain isolated--which is ultimately of most benefit to the veterans we provide treatment services for.

Our outpatient activities include a projected 2520 outpatient visits in FY 1988 (of which about 68% are group visits). We are unique, to my knowledge, regarding the extent of our off-station aftercare and pre-bed activities: four of our Vietnam veteran staff are off-stationed several hours, once weekly: (1) at the Seattle Vet Center, (2) with a State Department of Veterans Affairs fee-contractor in northern Seattle; (3) at the Tacoma Vet Center and (4) with a State Department of Veterans Affairs fee-contractor in Olympia. These four staff provide a "point man" type of contact for veterans tentatively exploring the possibility of entering our program, and primarily provide after-care treatment for veterans who would be at an unrealistic commuting distance from our program for any regular aftercare; such "satellite" services dramatically increase the geographic spread within which we can offer realistic regular aftercare -- to over 100 miles north and 75 miles south, southeast and southwest of our program. In addition, we provide five on-station after-care groups: spouse support group, couples' group, youth group (ages 11-19), work/school coping group, and war-focus/here-and-now combined group. We provide some limited individual and individual family counseling, but must keep this quite limited due to competing clinical needs. Our overall emphasis is on peer group treatment, both inpatient and outpatient, because we believe that is most impactful and resource efficient for most of the veterans we see.

In closing, I hope the above responses are sufficient; please feel free to call or write me for any additional information. We also strongly encourage any interested persons to talk to some of our program graduates or current inpatients to find out "what really goes on in the American Lake PTSTP," and would be happy to make the necessary arrangements.

Thank you for your continued and exemplary record regarding services to veterans of all eras.

Raymond M Scurfield

RAYMOND M. SCURFIELD, DSW, ACSW, LCSW
PTST Program Director

Enclosure

POST-TRAUMATIC STRESS TREATMENT PRINCIPLES June, 1988

by Raymond M. Scurfield, DSW, PTST Program Director, American Lake VAMC, Tacoma, WA.
Presented at CPC Fairfax Hospital Traumatic Stress Disorders Network Meeting(6/9/88)

1. Separation of compensation and treatment: it is essential that the treatment personnel not be the same persons who are involved in compensation recommendations. Our program utilizes strategies in this regard.

2. Establishment of the therapeutic trust relationship: with peer survivors, and with staff, both trauma survivors and others, male and female - and with a VA program. Persons with PTSD tend not to trust themselves and their powerful emotions, let alone trust others. Some clinicians contend that the establisiment of the trust relationship is the core of PTSD treatment with Vietnam veterans...

3. Education regarding the stress recovery process- is essential, in that there is so much misinformation about PTSD and prejudice re PTSD from both various clinicians and the public. Some core factors for the PTSD survivor to be aware of include: (a) symptoms usually get worst before they get better once PTSD-specific treatment is started; (b) it is expectable to have intrusive, painful recollections, numbing, rage, grief, etc., post-trauma; (c) symptoms do not necessarily get better over time; (d) for some survivors, symptoms increase over time; (e) some symptoms may never go away forever, completely (concept of co-existence with symptoms); and (f) PTSD definitely is responsive to knowledgeable PTSD-specific treatment.

4. Teaching various symptom-control techniques and strategies - prior to extensive trauma uncovering treatment: stress reduction/relaxation, anger/anxiety and sleep disturbance in particular.

5. Facilitation of an osuillation between numbing/avoidance and re-experiencing symptoms. Since ~~one~~ characteristic of PTSD is the involuntary intrusion of painful recollections and feelings, we teach persons how to enter into re-experiencing selected aspects of the trauma, and then to withdraw...

6. Re-experiencing the trauma-our experience is that patients must be willing to reexperience (with memories and expressed emotions) to some degree aspects of prior traumatic experiences in order to break through numbing and/or other emotional and cognitive blocks; the Gestalt Therapy of unfinished business is pertinent here, that unfinished psychological experiences demand attention in order to be put aside. The controlled experiencing also forces the patient to look at the trauma as if it were occuring now, rather than to be stuck in the position of looking at the trauma x years later, which is laden with intervening distortions and judgements...For veterans wounded in war, the whole med evac and hospital recovery process is treated in effect like a "second tour of duty" to be worked on.

** 7. Psychiatric medications - While we have found that the psycho-social treatment offered here is the primary treatment for most PTSD and associated problems, there are a number of war-zone vets who require some psychiatric medications for specific PTSD symptoms that are too severe to allow "processing" and counseling to occur,or that may not reduce or disappear enough with only counseling. Typically, some severe PTSD symptoms and the usualy psychiatric medication regimen is as follows:

(a) if there is an additional diagnosis of depression (in addition to PTSD), which occurs with up to 50% of our inpatients, tricyclic antidepressants are utilized: doxepin, and if too serious side-effects, desipramine (which usually is effective with more severe depression and PTSD). Trazodone also has been quite helpful. Sleep disturbance also is quite responsive to doxepin or trazodone.

** Information for this treatment principle provided by Alan Whitters, M.D., PTST Program medical director

(b) for severe anxiety: inderal (propranolol) (for periphal anxiety symptoms, such as elevated heart rate or blood pressure, tremulous, etc.); buspar if the anxiety is more psychological (e.g., the patient reports severe anxiety, but physical symptoms are not observable). We do not use any benzodiazepines (xanax, librium, valium, etc.) - we find the interactive effect with a substance abusing and numbing population to be counter to PTSD treatment.

(c) seizure disorders or organic brain syndrome: tegretol

(d) cyclical mood phenomena or impulsive hostility: lithium

(e) flashback (dissociative reaction) - clonidine; we use this on occasion only

(f) anti-psychotic medications - we do not use, and if are admitted on them, we taper them off gradually (the same with benzodiazepines).

(g) for outpatient treatment in aftercare, we tend to utilize trazodone (vs. doxepin), and buspar (vs. inderal), because of the no overdose potential.

The inherent problem: our patients tend to numb out to avoid powerful feelings and memories, and substance abuse for the same reasons, and we emphasize controlled reexperiencing and emotive expression as part of the healing process...
Also, when other psychiatric disorders co-exist with PTSD that medication treatment is indicated for (such as manic-depressive disorder), we prescribe such. However, because of our strong therapeutic milieu and philosophy, we are generally very conservative with psych medications.

8. Putting the trauma into a whole-life perspective: Most persons with PTSD tend to either over-emphasize the role of the trauma, or minimize the role; it is essential to place proper attention to pre-trauma, trauma and both immediate and longer-term post-trauma factors.

9. Trauma 'trailers' - In addition to the horror and pain of surviving the trauma per se that must be dealt with, the trauma survivor also must contend with the "baggage" that he/she attaches to the self. I call this the trauma trailer. What happens is that the survivor (with PTSD), in an attempt to "make some sense out of having been in the trauma, inevitably develops at least two profound existential statements -- one about the self, and one about others or the environment, i.e., "I'm no good;" I'm evil.." "No one is to be trusted or to be let close to me;" "no one could ever love me." The trailer is in effect the personal statement that the survivor makes (and judgement) about oneself as a result of how one experienced the trauma, and what one now believes about others.

/trauma

10. Integration of all aspects, both positive and negative, into the survivor's identity - who you are and where you are going to, so that you were resonsible for (and clarifying what you were not responsible for) is accepted, as well looking at the various aspects of the trauma experience that you continue to not acknowledge or minimize (such as personal strengths in surviving). This will enable you to think of everything, positive and negative, connected with your trauma experience, and not just dwell on the negatives. Example: when you think of Seattle Mariners, do you think "bad team," or do you think "baseball."

11. After-care: Following intensive inpatient treatment, all persons we treat need at least six months to three years of sustained after-care with someone - to continue to work on work not finished as an inpatient, to consolidate gains made, etc. It may be that an additional in-patient treatment phase will be needed later, due to the cyclical nature of the stress recovery process.

NOTE: Particularly problematic for us has been the combination of PTSD and substance abuse and the challenge of sequential vs. concurrent treatment for each. In addition, we have found the highest risk of suicide to be the combination of severe PTSD, substance abuse and chronic pain (usually from traumatic war injuries).

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1. The American Ex-Prisoners of War, on page 3 of its testimony, states that its belief that "There is a need for outreach efforts to [identify]...older veterans confronted with...belated stress reactions--and to provide brief therapeutic services [such] as those so successfully provided to [vietnam]...veterans via the outreach centers." Do you agree with the American Ex-Prisoners of War on this point and have you made any efforts to outreach to older veterans with PTSD?

Answer: We agree with the statement of the American Ex-Prisoners of War that outreach efforts to older veterans are needed. The Department of Medicine and Surgery and the Agency have a wide range of outreach activities which communicate the availability of and provide assistance to older veterans in gaining access to and utilizing the full range of VA Health Care and Benefit Services. Trained mental health professionals communicate and interpret the needs of and resources available to treat older veterans across a wide range of individual and community agency contacts, which include:

o Liaison and referral procedures with all community health and welfare agencies and community mental health centers within each VAMC's primary service area.

o Liaison/referral and joint planning efforts at national, state and local levels with the Administration on Aging, State Agencies on Aging and Area Agencies on Aging. (Members of our staff are appointed to and/or represent VA on the 664 Area Agencies on Aging.)

o Nationwide network of State and County Veteran Service Officers who serve as information and referral agents for individual veterans and organizations.

o Nationwide network of outreach through all Veteran Service Organizations, Service Officers and members--all of whom receive updated information regarding VA Health and Benefit services.

o Significant outreach efforts to Ex-POW's - the vast majority of whom are older veterans and, as a group, have the highest risk of experiencing PTSD of any group of veterans. Repeated contacts have been made over the past four years with all known Ex-POW's inviting them into VAMC's for completion of the extensive protocol examination which includes an extensive psychiatric and psychosocial assessment.

o Outreach through Ex-POW's, Veterans Service Organizations and Service Officers. (Most VAMC's have organized Ex-POW volunteers to outreach and facilitate utilization of VA services.)

SENATOR CRANSTON (continued)

o A wide range of individual and group treatment services have been developed at VAMC's and community locations. These treatment programs have resulted from the joint outreach efforts of VA staff and members of American Ex-POW Inc.

o Community presence and contacts made through Readjustment Counseling Service. While focused primarily on Vietnam Veterans contacts and referrals are frequently made on older veterans.

o Veterans Benefits Counselors/DVB outreach activity.

These efforts for Ex-POWs and other veterans of WWII and Korea, have been increasingly successful. A review of inpatients treated for PTSD from FY 84 to FY 87 shows an increase in WWII/Korea veterans of from 506 individuals (1984) to 757 individuals (1987). The annual survey of psychological counseling services for former POW's indicated that in 1987 there were 6,000 former POWs in counseling across the VA system. During 1989 we intend to provide updated information on PTSD through our existing network of community contacts including specific problems/manifestations which may be experienced by older veterans.

Question: 2. Please provide whatever data you have indicating the percentages of veterans served by Vet Centers or receiving mental health care at VA inpatient units and outpatient units who have service-connected disabilities of any kind and who have service-connected psychiatric disabilities.

Answer: The Readjustment Counseling program does not gather data on the percentages of veterans seen at vet centers who have service-connected disabilities.

For VA medical facilities a review of data for FY 1987 reveals that for inpatients, 1,055,835 patients of all diagnoses were discharged, 344,614 (32.6%) of whom were service-connected. For psychiatry bed sections in FY 1987, 194,607 patient discharges took place, 77,569 of which were service-connected (39.9%). For Outpatient care in FY 1987 a total 18,863,391) patients of all diagnoses were treated, 8,759,011 (46.4%) of whom were service-connected. The total patients treated in mental health outpatient programs during this period were 626,488 of whom 315,647 (50.1%) were service-connected. The nature of our data base is such that we cannot be certain that the service-connected patients discharged/treated in the mental health programs were always treated for their service-connected disorder, however, it is highly probable that the majority of them were treated for a service-connected mental disorder.

SENATOR CRANSTON

Question: 3. Please provide data showing for each regional office the numbers of claims for compensation based on PTSD, the numbers of awards of compensation based on such claims, and the percentage ratings thereof for FY 1984 through 87 and the first half of FY 88.

Answer: Data for FY 1984 are unavailable. We did not begin collecting PTSD data in SIRS until June 1, 1985. The remainder are attached.

Question: 4. With regard to providing assistance to veterans from earlier wars who may be suffering from PTSD, I note that, on page 3 of your statement, it is stated that "[G]roup psychotherapy or counseling is particularly effective for some veterans with PTSD, in that it furnishes the veteran with supportive comparisons and therapeutic help from peers." Does this suggest that if the agency seeks to assist such veterans through a *specialized* entity -- either Vet Centers or some *new* mechanism -- an emphasis should be placed as well on utilizing counselors who served during the earlier wars?

Answer: The reference on page 3 of our statement concerning supportive comparisons and therapeutic help from peers, is to peers who are fellow clients or patients, not to staff.

It is not clear that a new mechanism is required for the treatment of those veterans from earlier wars who suffer from PTSD. It would appear from reviews of the PTP and outpatient surveys (see question #1) that veterans from earlier war eras are coming to VA Medical Centers for PTSD care. The 3rd Annual Report of the Chief Medical Director's Special Committee on PTSD noted that 30.5% of all PTSD treated in VAMC outpatient programs is found in veterans outside the Vietnam era (21.7% from WWII, 5.1% Korean Conflict). We do not believe that a special entity such as Vet Centers is needed to attract WWII and Korean veterans into treatment. As for the use of group modalities for WWII and Korean veterans, these are being used, in some cases in groups of veterans of all eras, in other cases separately for veterans of different eras.

Question: 5. What mechanisms are in place to enable Vet Centers to share lessons learned about PTSD with other Vet Centers and with other VA programs.

Answer: Vet Center staff share lessons learned about PTSD through in-service training conferences of staff from multiple sites; through joint training exercises including both vet center staff and medical facility staff (a number of which have been carried out by DM&S during the past few years); through inclusion of medical center staff in regular Readjustment Counseling Service training conferences; and through regular weekly clinical conferences of vet center and medical facility staff.

SENATOR CRANSTON

Question: 6. On page 22 of your statement, you discuss the requirements that must be met before a regional office can grant service connection for PTSD. The second requirement is that "There must be documentation from military records which supports the reasonable conclusion that the alleged event did occur." Please elaborate on this statement and, in so doing, please explain what more is needed if the record supports a finding that the veteran was assigned to a unit that participated in combat operations.

Answer: As discussed during our testimony, service connection for PTSD can be granted only if an in-service traumatic stressor can be identified. While the stressful event does not have to be documented to an absolute certainty, the supportive evidence of record must be sufficient to permit a rating board to reasonably conclude that the stressful event occurred as claimed.

Guidelines provided in DVB Circular 21-86-10 specify that receipt of a Purple Heart, a Combat Infantryman Badge, a Bronze Star or a similar citation is to be considered "supportive evidence." Other supportive evidence includes but is not limited to: evidence of involvement in a plane crash, ship sinking, or explosion; duty in a burn ward, graves registration unit or similar assignments; or being the victim of a rape or an assault. Prisoner of War status is conclusive evidence of an in-service stressor.

In cases where the records available to the rating board do not provide objective or supportive evidence of the claimed traumatic event, the veteran is requested to furnish specific details about the stressful incident. In addition, the service department is asked to furnish copies of appropriate pages from the veteran's personnel file showing unit assignments, dates of assignments, participation in combat operations, etc. The information obtained from both these sources is forwarded to the U.S. Army and Joint Services Environmental Support Group. That organization researches morning reports and other military records in order to provide supportive evidence pertaining to the alleged stressor.

The fact that a veteran was assigned to a unit which participated in combat operations is an important piece of information, but is not in and of itself conclusive evidence. At any given point in time a member of such a unit may have been performing non-combat duties, temporarily detailed to other locations or assignment, undergoing treatment at a medical facility, in R and R status, etc. Furthermore, rating boards do not have access to records that specify which units participated in combat operations and the dates of those operations.

Therefore, when the veteran or the evidence of record indicates that he was assigned to a combat unit (but was not awarded one of the medals specified above), all available information is sent to the U.S. Army and Joint Services Environmental Support Group. If their research provides information which corroborates the occurrence of the traumatic event, service connection for PTSD may be granted.

SENATOR CRANSTON

Question: 7. As requested earlier by telephone, for each specialized inpatient treatment program, please list the time a veteran must wait for a bed opening, the number of veterans waiting as of July 1, and the percentage of veterans who, having finished the treatment, return for further inpatient or outpatient treatment.

Answer: While we do have information on number of patients on waiting list, waiting time and percent of patients successfully completing the Specialized Inpatient PTSD Treatment Unit (SIPU) programs we do not, at this time, have information on the number of completing patients who return for further treatment or aftercare. This information will probably be a feature of the SIPU program evaluation which is being planned.

FACILITY	NUMBER OF PATIENTS ON WAITING LIST	WAITING TIME	% OF ADMITTED PATIENT WHO SUCCESSFULLY COMPLETED PROGRAM
VAMC Buffalo, NY	45	6 1/2 wks	67%
VAMC Montrose, NY	16	5 wks	72%
VAMC Northampton, MA	48	up to 8 wks	81%
VAMC Togus, ME	15	8 wks	63%
VAMC Coatesville, PA	0	2-4 wks	91%
VAMC Lyons, NJ	4	2 1/2 wks	95%
VAMC Augusta, GA	30	4-8 wks	61%
VAMC Bay Pines, FL	6-8	up to 3wks	78%
VAMC Cleveland, OH	20 waiting for assessment 20 waiting for treatment	6 wks	data not available
VAMC N. Chicago, IL	45	10 wks	71%
VAMC Tomah, WI	6	4 wks	data not available
VAMC Topeka, KS	12-14	6 wks	90%
VAMC Palo Alto, CA	14	1 wk	90%
VAMC Tacoma, WA	66 waiting for assessment 68 waiting for treatment	up to 6 mos. (24 wks)	94%
VAMC Little Rock, AR	100	3 mos (12 wks)	data not available (new program)
VAMC Phoenix, AZ	37 waiting for assessment 0 waiting for treatment	6 mos. (24 wks) 3 wks	81%

SENATOR CRANSTON (continued)

A total of 554 patients were noted as being on the waiting list, an average of 35/SIPU. The range was from 0-100 patients, with the one unit with a waiting list of 100 being a program that was just beginning operation.

The average waiting time for treatment for the 16 programs is 6.9 weeks with a range of 1 week to 24 weeks. For the thirteen programs that provided data on program completion, an average of 79.5% patients admitted successfully completed the course of treatment.

Question: 8. In the specialized inpatient programs, what percentage of the patients have a history of substance abuse, and of that percentage, what percentage have had admission to substance abuse treatment programs?

Answer: This information is currently being gathered by the Chief Medical Director's Special Committee on PTSD for inclusion in its 5th Annual Report. PTF survey data in 1984 suggested the 55.5% of Vietnam Era Veterans discharged with PTSD also had alcohol/substance dependent or non-dependent abuse. The 3rd Annual Report of the CMD's Special Committee on PTSD noted that the percentage of veterans in alcohol/drug treatment programs who were also diagnosed as having PTSD was only 2.6% of all visits. These findings have focused increasing attention on education and programs development in the area of PTSD and Alcohol/substance abuse co-morbidity.

Question: 9. At the July 14 hearing on PTSD, a number of witnesses articulated a need to involve the family and/or spouse in the treatment of the veteran's PTSD, yet the latest VA reimbursement policy for collateral visits is to provide a flat $100 per capita reimbursement per unique collateral social security number. This reimbursement formula would seem to ensure that unless a particular VAMC can "afford" under the RAM to offer help to families at no direct cost to the PTSD programs, PTSD family-related issues are not given the attention required by VA practitioners in order to treat successfully the veteran's PTSD; this in turn may end up not only with an unsuccessful treatment regimen but with an unnecessarily prolonged one. Please comment on this situation and any plans you have to take family-related treatment needs more fully into account in the RAM.

SENATOR CRANSTON (continued)

Answer: There has been an increasing awareness of both the family pathology associated with PTSD and the value of involving the family in treatment at some point. PTSD treatment programs continue to treat the families of veterans with PTSD when this is clinically indicated as part of the veterans care. A working group chaired by the ACMD for Clinical Affairs has revised the definition of a "collateral" to specifically link the VA's contact with this non-veteran individual to the treatment plan of the veteran patient. This new definition, when it is published to the field, will be the first step in documenting those clinical situations for which a greater reimbursement for collateral visits would be appropriate. We are working to insure that collateral visits associated with the treatment of Category A and service-connected veterans be eligible for an appropriate level of reimbursement.

Question: 10. According to the director of the PTSD unit at American Lake, there has been some difficulty in getting high enough grade levels classified to be able to attract qualified persons with substantial experience in PTSD treatment, but without an MSW, Ph.D., or RN degree, yet the grading structure in the Vet Center program is significantly more liberal in terms of giving credit, grade-wise, for relevant experience and various educational attainments short of a degree. For example, American Lake has not been authorized to start above a GS-9 for an employee with a master's degree plus substantial PTSD experience. Not only is this counterproductive for the PTSD treatment units but it blocks a logical and desirable career path for former Vet Center personnel, a path which DM&S should be doing all it can to open up. Please comment on this situation.

Answer: The Vet Center program grade structure was specifically designed to allow for maximal consideration of relevant war and post-war life-experience (in addition to formal degrees), such as war-service, post war peer-counseling in voluntary and/or paid positions, etc. This was done because of the perception, at the time the Vet Center program was established, in 1978, that many vietnam veterans were so alienated from society, that they would shun contact with counselors who they did not consider peers based upon common (Vietnam) experience. Over the years, the Vet Centers have moved away from this almost-exclusive emphasis on war and life-experience as a criterion for counselors and moved towards professional mental health and other counseling credentials in their hiring. This is a result of both the increasing complexity of cases presenting to all Vet Centers and the increasing acceptance of Vet Center and other VA services by Vietnam veterans. It is our contention that quality of care is related to appropriate criteria for credentialing and privileging of health care personnel and that veterans are best served when these criteria are based on objective evidence of training and clinical performance. We know from our experiences with alcohol counselors, that careful credentialing can result in quality staff

SENATOR CRANSTON (continued)

performance. The grade structure is currently present at ALVAMC PTSD Programs to have a reasonable career ladder for earlier level peer counselors (e.g., Mental Health Associate GS-6 and 7, and Social Science Specialist GS-7 or 9). On the other hand, GS-10, 11 or 12 positions have not been authorized to date.

Question: 11. To address the issue of encouraging women veterans to seek treatment for PTSD, Dr. Scurfield suggested that two or three of the designated specialized PTSD programs be identified, and provided with some additional resources, as centers for treatment of women war veterans (as well as male veterans), and so advertised throughout the VA and community systems. He testified: "Appropriately developed with staff expertise, targeted outreach efforts and promoting coordinated small-group (of women war-vets) cohort admissions, in my opinion, would promote and optimize the number of women veterans with severe PTSD willing to enter inpatient PTSD treatment." In view of the RTI finding that 9% of women Vietnam veterans are suffering PTSD, please comment on this proposal, and provide your assessment of the anticipated response such programs would receive from women veterans, if two to three units were designated and equipped as treatment programs especially meant for women veterans.

Answer: A survey of VA mental health treatment programs, completed in October 1988, revealed 13 VA Medical Centers with women's programs for PTSD. The programs reported seeing a total of fifty women in the thirty days prior to the survey. The RTI study suggests that 9% of women Vietnam veterans are suffering from PTSD; a total of 800-900 veterans. The RTI study indicates some 400,000 Vietnam veterans overall with some form of PTSD. Given these numbers, it is the VA's plan to promote the treatment of women PTSD sufferers by continuing the ongoing program of education on the needs of women with PTSD and by encouraging the local treatment of these veterans wherever possible. Outreach to female veterans will also continue. When the final RTI report is submitted and reviewed, information on the geographic distribution of veterans with PTSD will assist program planning.

Question: 12. Are there nationally designated catchment areas for each of the specialized inpatient treatment units? If so, please provide them; if not, please elaborate on why not and advise if they will be developed.

Answer: There are not nationally designated catchment areas for each of the Specialized Inpatient PTSD Treatment Units, (SIPU) nor is there a plan to develop them. Logically, most of the patients seen at a given SIPU will tend to come from that locale but this is not an absolute requirement. This allows the flexibility for referral of patients to a specific SIPU based on clinical indications or patient request. It should be noted that VA Medical Centers have a

SENATOR CRANSTON (continued)

Primary Service Area, a geographic area of clinical responsibility: the SIPUs have not been officially charged or funded for a larger area of responsibility. Rather than establishing catchment areas for existing SIPUs, it is the VA's plan to meet PTSD treatment needs through education of clinicians and the development of local PTSD treatment capabilities.

Question: 13. Please outline what, if any, methods are utilized to facilitate communication among the specialized inpatient units, and comment on the proposal to have, at a minimum, a yearly meeting of the directors of the PTSD units.

Answer: The already existing mechanism for communication among SIPUs is the Quarterly PTSD Newsletter that is published and circulated from VAMC, Brecksville through the Cleveland (Mid-Atlantic) RMEC. PTSD Treatment Teams are also being included in this publication. The concept of a yearly meeting of SIPU directors or directors and staff, is a fine one except for the realities of our shrinking fiscal resources. Since 1984, there have been two national meetings of SIPU directors and staff. The latest one being in 1987. In 1988, the first national meeting for PTSD Treatment Teams was held, with great success. A previous attempt at regular telephone conferences was not successful. At this point we must continue to rely on the Quarterly Newsletter as the primary means of regular inter-SIPU communication, with face-to-face meetings when resources allow.

Question: 14. Please comment on the assertion by the Disabled American Veterans that the VA is using to treat PTSD non-VA contract physicians who have little or no expertise or experience in treating and diagnosing PTSD.

Answer: Insofar as the DAV assertion might refer to the Readjustment Counseling Service (RCS) contract program, all contractors retained under this program must submit a proposal which outlines in considerable detail the training and experience of the contract provider regarding PTSD, and such training and experience is used as an evaluation criterion in awarding contract provider status. Maximum feasible efforts are made to obtain providers with expertise and experience regarding PTSD. Readjustment Counseling Service contract operations are subject to oversight and review from local and regional management officials. The vet center team leader, functioning in the capacity of the Contracting Officer's Technical Representative (COTR), provides local oversight regarding adherence to appropriate clinical and administrative procedures. Regional officials review contract operations during routinely scheduled clinical and administrative site visits to vet centers. Also, vet center operations, including the contracts program, have been incorporated into routine DM&S Systematic External Review Program (SERP) visits to medical facilities inclusive of RCS staff

SENATOR CRANSTON (continued)

on SERP teams. Individual contract providers, where feasible, are also invited to participate in RCS staff training as students or faculty as appropriate.

The use of non-VA contract physicians, to treat patients from VAMCs or outpatient clinics is extremely limited and based, usually, on issues of geographic proximity to the patient. In such cases the qualifications of the contract physician to treat the disorder would have to be acceptable to VA staff prior to referral.

VA Regional Offices

No.	Name	No.	Name
301	Boston, MA	402	Togus, Mc
304	Providence, RI	405	White River Jct., VT
306	New York, NY	436	Ft. Harrison, MT
307	Buffalo, NY	437	Fargo, ND
308	Hartford, CT	438	Sioux Falls, SD
309	Newark, NJ	442	Cheyenne, WY
310	Philadelphia, PA	452	Wichita, KS
311	Pittsburgh, PA	455	San Juan, PR
313	Baltimore, MD	460	Wilmington, DE
314	Roanoke, VA		
315	Huntington, WV		
316	Atlanta, GA		
317	St. Petersburg, FL		
318	Winston-Salem, NC		
319	Columbia, SC		
320	Nashville, TN		
321	New Orleans, LA		
322	Montgomery, AL		
323	Jackson, MS		
325	Cleveland, OH		
326	Indianapolis, IN		
327	Louisville, KY		
328	Chicago, IL		
329	Detroit, MI		
330	Milwaukee, WI		
331	St. Louis, MO		
333	Des Moines, IA		
334	Lincoln, NE		
335	St. Paul, MN		
339	Denver, CO		
340	Albuquerque, MN		
341	Salt Lake City, UT		
343	San Francisco,CA		
344	Los Angeles, CA		
345	Phoenix, AZ		
346	Seattle, WA		
347	Boise, ID		
348	Portland, OR		
349	Waco, TX		
350	Little Rock, AR		
351	Muskogee, OK		
354	Reno, NV		
358	Manila, PI		
359	Honolulu, HI		
362	Houston, TX		
363	Anchorage, AK		
372	Washington, DC		
373	Manchester, NH		
377	San Diego, CA		

09-23-85 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 1 COIN CP136

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO RVA TOTAL	REFERRED TO RVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
301	90	64	71.1	25	27.8	1	1.1						
304	22	14	63.6	8	36.4							1	1.1
306	132	58	43.9	74	56.1								
307	58	41	70.7	17	29.3								
308	49	29	59.2	20	40.8								
309	106	78	73.6	28	26.4								
310	158	49	31.0	109	69.0								
311	48	29	60.4	19	39.6								
313	45	21	46.7	24	53.3								
314	142	58	40.8	84	59.2								
315	36	19	52.8	17	47.2								
316	76	49	64.5	27	35.5								
317	216	127	58.8	89	41.2								
318	38	17	44.7	21	55.3								
319	25	16	64.0	9	36.0								
320	37	21	56.8	16	43.2								
321	17	9	52.9	8	47.1								
322	23	9	39.1	14	60.9								
323	31	18	58.1	13	41.9								
325	208	102	49.0	106	51.0								
326	41	15	36.6	26	63.4								
327	68	46	67.6	22	32.4								
328	23	15	65.2	8	34.8								
329	81	30	37.0	51	63.0								
330	225	129	57.3	96	42.7								
331	37	20	54.1	17	45.9								
333	38	19	50.0	19	50.0								
334	7	4	57.1	3	42.9								
335	59	26	44.1	33	55.9								
339	76	58	76.3	18	23.7								
340	8	2	25.0	6	75.0								
341	24	19	79.2	5	20.8								
343	81	41	50.6	40	49.4								
344	79	34	43.0	45	57.0								
345	74	49	66.2	25	33.8								
346	190	100	52.6	90	47.4								
347	31	27	87.1	4	12.9								
348	101	45	44.6	56	55.4								
349	65	21	32.3	44	67.7								
350	38	20	52.6	18	47.4								
351	32	10	31.3	22	68.8								
354	3	2	66.7	1	33.3								
359	26	16	61.5	10	38.5								
362	29	14	48.3	15	51.7								
363	5	3	60.0	2	40.0								
372	8	5	62.5	3	37.5								
373	36	29	80.6	7	19.4								
377	32	18	56.3	14	43.8								
402	41	12	29.3	29	70.7								
405	5	3	60.0	2	40.0								
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								

09-23-85 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 2 COIN CP136

RO	TOTAL CLAIMS	APPROVED		DISAPPROVED		PENDING		REFERRED TO BVA		REFERRED TO ARMY		REFERRED TO VACO	
		TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%
437	14	10	71.4	4	28.6								
438	18	8	44.4	10	55.6								
442	12	4	33.3	8	66.7								
452	33	22	66.7	11	33.3								
455	5	2	40.0	3	60.0								
TOTAL	3243	1724	53.2	1518	46.8	1	0.0					1	0.0

9-23-85 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 1 COIN CP134

	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
301	1	14		22		7		6			14	64
304		7		5				2				14
306	1	13		28		10		2			5	59
307		11		19		8		1			2	41
308	2	9		4		2		2			10	29
309	1	22		35		14		2			4	78
310	1	24		13		7		2			2	49
311	4	13		11		1						29
313		12		7		1					1	21
314	2	19		15		11		3			8	58
315	1	2		10		5		1				19
316	2	18		9		7		3			10	49
317	2	41		44		21		4			10	122
318	3	7		5		2						17
319	1	9		3		2		1				16
320		11		7		3						21
321	1	5				2					1	9
322		5		2		2						9
323	4	2		5		4		2			1	18
325	1	42		41		13		1			4	102
326	2	3		5		2					3	15
327	2	5		14		11		1			13	46
328	2	10		2							1	15
329	2	15		10		2		1				30
330	4	31		32		28		4			20	120
331	5	4		5		3					3	20
333	1	10		5		1					2	19
334	1	2		1								4
335	2	11		9		3					1	26
339	6	18		20		8		1			5	58
340				1							1	2
341		3		7		6		2			1	19
343	6	23		4		6					2	41
344	9	17		4		3					1	34
345	2	29		10		4		2			2	49
346	7	40		31		13		5			4	100
347	3	14		8		2						27
348		10		29		5					1	45
349	1	8		7		12					2	30
350		4		2		4		5			5	20
351		5				1		1			3	10
354				2								2
359	1	10		4		1						16
362	1	5		4		3					1	14
363		1				1					1	3
372		2		2							1	5
373		6		11		7		1			4	29
377	1	10		5		2						18
402		7		4		1						12
405				2		1						3

09-23-85 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 2 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
437		6		3							1	10
438		2		3		2					1	8
442		2		1		1						4
452		4		9		5		1			3	22
455		2										2
TOTAL	85	609		550		260		52			168	1725
	5%	35%		32%		15%		3%			10%	

09-25-86 REPORT 1[illegible] POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 1 CUTM CP130

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO RVA TOTAL	REFERRED TO RVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
301	462	339	73.4	122	26.4	1	0.2					1	0.2
304	105	78	74.3	27	25.7								
306	534	236	44.2	298	55.8								
307	297	192	64.6	105	35.4								
308	148	88	59.5	60	40.5								
309	358	241	67.3	117	32.7								
310	677	269	39.7	408	60.3								
311	215	113	52.6	102	47.4								
313	165	84	50.9	81	49.1								
314	455	196	43.1	259	56.9								
315	225	120	53.3	105	46.7								
316	230	133	57.8	97	42.2								
317	812	485	59.7	327	40.3								
318	123	74	60.2	49	39.8								
319	84	43	51.2	41	48.8								
320	144	86	59.7	58	40.3								
321	68	34	50.0	34	50.0								
322	107	45	42.1	62	57.9								
323	108	51	47.2	57	52.8								
325	897	448	49.9	449	50.1								
326	140	56	40.0	84	60.0								
327	302	170	56.3	131	43.4	1	0.3	1	0.3				
328	182	117	64.3	65	35.7								
329	244	90	36.9	154	63.1								
330	693	396	57.1	297	42.9								
331	161	103	64.0	58	36.0								
333	120	60	50.0	60	50.0								
334	37	19	51.4	18	48.6								
335	158	67	42.4	91	57.6								
339	162	116	71.6	46	28.4								
340	91	54	59.3	37	40.7								
341	51	44	86.3	7	13.7								
343	274	150	54.7	124	45.3								
344	439	149	33.9	290	66.1								
345	223	163	73.1	60	26.9								
346	666	356	53.5	310	46.5								
347	101	78	77.2	23	22.8								
348	370	192	51.9	178	48.1								
349	369	122	33.1	247	66.9								
350	161	89	55.3	72	44.7								
351	103	37	35.9	66	64.1								
354	17	5	29.4	12	70.6								
359	108	73	67.6	35	32.4								
362	83	45	54.2	38	45.8								
363	17	13	76.5	4	23.5								
372	23	13	56.5	10	43.5								
373	152	103	67.8	49	32.2								
377	193	95	49.2	98	50.8								
402	200	125	62.5	62	31.0	9	4.5	4	2.0	5	2.5		
405	19	13	68.4	6	31.6								
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO PVA TOTAL	REFERRED TO PVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
437	45	30	66.7	15	33.3								
438	57	33	57.9	24	42.1								
442	49	24	49.0	25	51.0								
452	103	66	64.1	37	35.9								
455	22	6	27.3	15	68.2	1	4.5	1	4.5				
460	12	2	16.7	10	83.3								
TOTAL	12530	5758	55.9	5740	46.0	12	0.1	6	0.0	5	0.0	1	0.0

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09-23-86 REPORT 19 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 1 CCIN CP136

RO	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
301	1	47		129		63		21			32	326
304		27		18		21		3			8	77
306	4	68		87		50		13			11	233
307	8	35		86		38		8			14	189
308	2	30		17		6		5			27	87
309	3	36		95		80		3			12	229
310	1	107		98		32		10			15	263
311	14	55		34		4		3				110
313	5	28		32		10		4			3	82
314	7	73		56		33		5			22	196
315	2	28		46		32		3			10	121
316	4	34		23		24		5			19	131
317	9	149		135		72		22			66	453
318	6	29		27		6		1			1	70
319	4	21		9		4		1			3	42
320	7	43		24		10		1			2	87
321		10		12		9					3	34
322	3	19		13		5		1			1	43
323	4	14		14		6		4			2	44
325	2	111		181		77		32			27	430
326	3	23		13		9					7	55
327	7	31		62		32		3			32	167
328	7	55		37		7		1			5	115
329	3	14		22		12		4			3	90
330	3	75		135		90		23			52	384
331	11	39		27		11		1			2	91
333	1	42		10		3					3	59
334	3	7		5							3	18
335	7	24		21		9		1			4	66
339	13	70		53		16		3			9	164
340	7	13		12		10		5			5	52
341		12		13		12		4			3	49
343	23	[illegible]		35		11		3			5	155
344	32	7		20		7		3			3	143
345	3	[illegible]		14		17		4			7	172
346	27	[illegible]		127		57		13			17	347
347	5	[illegible]		22		5					2	75
348	2	[illegible]		90		33		7			6	184
349	[illegible]	[illegible]		39		35		8			22	141
350		10		20		20		15			21	86
351	2	15		5		5		4			8	37
354		1		4								5
359	2	39		27		5						73
362	3	12		11		5		1			8	41
363	3	4		2		3		1				13
372		3		3		3					3	12
373	6	23		44		22		3			9	103
377	8	39		27		14		4			1	93
402	7	42		37		24		5			10	125
403	1	[illegible]		5		2						13
[illegible]											[illegible]	[illegible]

09-23-86 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 2 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
437		10		13		3					3	29
438		13		10		3		3			2	31
442	1	4		5		3		1			4	23
452		20		22		8		2			10	62
455		2		1		2					2	7
480		1		1								2
TOTAL	233	2255		2157		1092		269			546	6555

02-25-87 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 1 COIN CP135

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO BVA TOTAL	REFERRED TO BVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
301	757	541	71.5	215	28.4	1	0.1					1	0.1
304	212	156	73.6	56	26.4								
305	843	409	48.5	434	51.5								
307	598	356	59.5	241	40.3	1	0.2	1	0.2				
308	244	144	59.0	100	41.0								
309	711	509	71.6	201	28.3	1	0.1					1	0.1
310	1030	445	43.2	585	56.8								
311	343	184	53.6	159	46.4								
313	251	132	52.6	119	47.4								
314	776	353	45.5	423	54.5								
315	399	228	57.1	171	42.9								
316	388	227	58.5	161	41.5								
317	1417	793	56.0	623	44.0	1	0.1	1	0.1				
318	273	162	59.3	111	40.7								
319	179	105	58.7	74	41.3								
320	314	186	59.2	128	40.8								
321	210	93	44.3	117	55.7								
322	219	82	37.4	135	61.6	1	0.5	1	0.5				
323	219	104	47.5	115	52.5								
325	1465	734	50.1	731	49.9								
326	233	93	39.9	140	60.1								
327	566	323	57.1	242	42.8	1	0.2					1	0.2
328	270	170	63.0	100	37.0								
329	351	151	43.0	200	57.0								
330	1137	647	56.9	490	43.1								
331	344	194	56.4	150	43.6								
333	198	93	47.0	105	53.0								
334	89	40	44.9	49	55.1								
335	267	106	39.7	161	60.3								
339	496	339	68.3	157	31.7								
340	229	130	56.8	99	43.2								
341	101	89	88.1	12	11.9								
343	510	304	59.6	206	40.4								
344	785	260	33.1	523	66.6	2	0.3	2	0.3				
345	403	290	72.0	113	28.0								
346	1144	686	60.0	458	40.0								
347	161	116	72.0	45	28.0								
348	621	311	50.1	310	49.9								
349	719	290	40.3	429	59.7								
350	260	156	60.0	104	40.0								
351	297	117	39.4	180	60.6								
354	34	10	29.4	24	70.6								
358	187	146	78.1	41	21.9								
362	160	84	52.5	76	47.5								
363	52	40	76.9	12	23.1								
372	32	16	50.0	16	50.0								
373	310	219	70.6	91	29.4								
377	348	164	47.1	184	52.9								
402	315	173	51.1	116	35.7	7	2.2	1	0.3	5	1.9		
405	95	68	71.6	27	28.4								
436	72	40	55.6	32	44.4								

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09-25-87 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 2 CODE CP135

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO PVA TOTAL	REFERRED TO PVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
437	71	44	62.0	27	38.0								
438	88	52	59.1	36	40.9								
442	97	36	37.1	61	62.9								
452	265	167	63.0	95	35.8	3	1.1	2	0.8			1	0.4
455	125	49	39.2	75	60.0	1	0.8					1	0.8
463	28	13	46.4	14	50.0	1	3.6			1	3.6		
TOTAL	22309	12159	54.6	10100	45.3	20	0.1	8	0.0	7	0.0	5	0.0

[illegible]

NO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
301	9	129		194		109		25			53	520
304	1	47		43		41		5			17	154
305	14	35		154		98		23			35	412
307	10	105		126		72		18			24	355
308	6	38		34		12		7			44	141
309	7	145		245		69		13			21	437
310	6	168		172		48		17			25	434
311	21	102		43		7		2				183
313	7	40		45		23		8			5	129
314	8	108		117		64		13			41	351
315	2	41		86		59		9			25	223
316	10	92		41		39		7			31	213
317	22	233		224		132		44			105	761
318	7	64		54		17		2			7	151
319	9	45		20		15		3			11	103
320	13	90		51		19		5			7	135
321	3	32		30		15					5	85
322	4	39		24		8		3			1	79
323	6	32		30		14		6			5	94
325	7	186		232		118		52			47	704
326	3	42		28		7					13	93
327	12	58		108		65		17			53	313
328	9	89		53		9		2			5	167
329	11	69		42		18		7			5	153
330	5	133		234		140		37			93	542
331	13	75		49		23		4			3	167
333	4	53		21		8					5	91
334	8	14		10				1			4	37
335	8	41		31		14		4			4	102
339	12	133		116		35		10			23	333
340	10	49		23		27		10			6	125
341		22		31		20		8			5	87
343	39	148		73		28		5			5	297
344	46	140		55		10		5			[illegible]	261
345	14	145		66		26		7			[illegible]	257
346	53	131		223		121		25			37	503
347	11	49		43		9		1			1	114
348	5	79		142		52		17			5	301
349	5	54		85		72		14			51	253
350	5	14		38		43		24			30	152
351	4	37		24		21		7			25	119
356		3		6		1						13
359	9	68		51		13		7			2	153
362	15	25		14		11		5			7	79
363	4	10		11		10		2			3	40
372		3		3		5		1			4	15
373	2	53		91		36		13			23	219
377	10	67		49		26		5			4	161
402	11	54		57		34		12			25	194
405	2	16		30		7		3			9	67
[illegible]	2	21		11		3		2			1	[illegible]

07-25-87 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 2 COIN CP135

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
437		18		18		3					4	43
433		19		13		8		2			9	51
442	1	17		8		3		3			3	35
452	1	39		44		23		11			37	155
455	1	9		14		10		4			5	43
463	1	3		5		3		1				13
TOTAL	515	3881		3921		1942		560			1043	11457

05-24-88 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 1 COIN CP136

RO	TOTAL CLAIMS	APPROVED		DISAPPROVED		PENDING		REFERRED TO BVA		REFERRED TO ARMY		REFERRED TO VACO	
		TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%
301	938	672	71.6	264	28.1	2	0.2	1	0.1			1	0.1
304	276	205	74.3	71	25.7								
306	1053	527	50.0	526	50.0								
307	788	457	58.0	330	41.9	1	0.1	1	0.1				
308	277	162	58.5	115	41.5								
309	931	683	73.4	247	26.5	1	0.1					1	0.1
310	1276	581	45.5	695	54.5								
311	435	244	56.1	191	43.9								
313	297	151	50.8	146	49.2								
314	982	460	46.8	522	53.2								
315	549	308	56.1	241	43.9								
316	532	313	58.8	219	41.2								
317	1851	988	53.4	861	46.5	2	0.1	2	0.1				
318	317	188	59.3	129	40.7								
319	265	158	59.6	107	40.4								
320	420	240	57.1	180	42.9								
321	317	152	47.9	165	52.1								
322	334	129	38.6	204	61.1	1	0.3	1	0.3				
323	320	171	53.4	149	46.6								
325	1799	896	49.8	902	50.1	1	0.1	1	0.1				
326	314	118	37.6	196	62.4								
327	711	393	55.3	317	44.6	1	0.1					1	0.1
328	422	254	60.2	168	39.8								
329	411	181	44.0	230	56.0								
330	1399	775	55.4	624	44.6								
331	430	235	54.7	195	45.3								
333	242	115	47.5	127	52.5								
334	108	49	45.4	59	54.6								
335	316	127	40.2	189	59.8								
339	669	454	67.9	215	32.1								
340	320	168	52.5	152	47.5								
341	151	117	77.5	34	22.5								
343	743	446	60.0	297	40.0								
344	1004	339	33.8	663	66.0	2	0.2	2	0.2				
345	614	442	72.0	172	28.0								
346	1472	866	58.8	606	41.2								
347	203	137	67.5	66	32.5								
348	802	405	50.5	397	49.5								
349	965	416	43.1	549	56.9								
350	352	213	60.5	139	39.5								
351	452	191	42.3	261	57.7								
354	56	20	35.7	36	64.3								
359	262	197	75.2	65	24.8								
362	284	142	50.0	142	50.0								
363	83	63	75.9	20	24.1								
369	2	2	100										
372	48	24	50.0	24	50.0								
373	374	268	71.7	104	27.8	2	0.5	2	0.5				
377	454	231	50.9	223	49.1								
402	374	230	61.5	134	35.8	10	2.7	3	0.8				
405	125	92	73.6	33	26.4								

05-24-88 REPORT 10 POST-TRAUMATIC STRESS DISORDER SUMMARY PAGE 2 COIN CP136

RO	TOTAL CLAIMS	APPROVED TOTAL	APPROVED %	DISAPPROVED TOTAL	DISAPPROVED %	PENDING TOTAL	PENDING %	REFERRED TO RVA TOTAL	REFERRED TO RVA %	REFERRED TO ARMY TOTAL	REFERRED TO ARMY %	REFERRED TO VACO TOTAL	REFERRED TO VACO %
436	113	61	54.0	52	46.0								
437	89	59	66.3	30	33.7								
438	110	63	57.3	47	42.7								
442	119	45	37.8	74	62.2								
452	392	238	60.7	152	38.8	2	0.5	2	0.5				
455	169	66	39.1	102	60.4	1	0.6					1	0.6
460	60	30	50.0	29	48.3	1	1.7			1	1.7		
TOTAL	29171	15957	54.7	13187	45.2	27	0.1	15	0.1	8	0.0	4	0.0

05-24-88 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 1 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
301	10	158		234		136		37			70	645
304	1	51		61		57		5			27	202
306	16	113		184		135		36			41	525
307	14	127		169		86		21			40	457
308	8	45		35		18		11			43	160
309	10	182		311		113		22			27	665
310	6	218		223		68		21			25	561
311	30	142		51		10		7				240
313	9	41		45		36		10			8	149
314	11	142		150		80		14			57	454
315	4	51		121		79		14			32	301
316	15	113		65		50		13			46	302
317	29	281		289		149		54			141	943
318	6	78		62		20		2			9	177
319	9	61		33		23		5			17	148
320	13	111		70		25		7			10	236
321	3	54		48		26		1			7	139
322	4	59		41		15		2			2	123
323	6	53		47		27		12			13	158
325	6	226		346		155		57			70	860
326	3	57		32		8		1			12	113
327	17	71		138		75		16			72	389
328	13	129		82		18		2			7	251
329	15	83		49		22		5			9	183
330	8	147		280		169		42			113	759
331	19	86		60		27		5			6	203
333	4	55		38		12		1			4	114
334	9	19		11		1		1			4	45
335	12	45		39		17		5			7	125
339	22	171		148		61		14			33	449
340	15	66		33		30		12			10	166
341		25		40		26		12			9	112
343	51	212		120		35		8			7	433
344	56	186		73		13		7			7	342
345	21	215		104		35		9			16	400
346	67	268		268		144		38			47	832
347	15	64		43		11		2			1	136
348	9	101		184		64		21			14	393
349	9	77		110		98		28			79	401
350	5	22		62		52		30			39	210
351	7	56		35		31		11			43	183
354	2	11		5		1					1	20
359	22	89		53		20		7			8	199
362	21	44		28		17		6			17	133
363	5	18		18		14		2			6	63
369		1		1								2
372		6		4		8		1			4	23
373	3	57		111		51		17			27	266
377	10	92		77		33		8			6	226
402	17	62		65		40		15			31	230
405	2	23		34		12		5			12	88

05-24-88 REPORT 14 DISABILITY CLAIMS APPROVED FOR POST-TRAUMATIC STRESS DISORDER PAGE 2 COIN CP136

RO	0 %	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	TOTAL
436	2	31		18		5		2			3	61
437	1	25		21		5					6	58
438		21		15		11		4			11	62
442	3	17		13		3		5			3	44
452	11	54		69		35		16			39	224
455	4	11		15		13		9			7	59
460	1	4		9		10		4			2	30
TOTAL	691	5027		5090		2535		722			1407	15472

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1. Is there a cure for PTSD?

Answer: PTSD is an eminently treatable disorder - especially if the symptoms are recognized and addressed when first occurring. With the passage of time, the symptoms become more ingrained into the patient's life style and resolution may be more problematic. However, even the most severe and chronic forms are responsive to therapeutic interventions which at the least may help the patient cope more effectively with some aspects of the disorder.

Treatment modalities vary depending on the overall clinical picture. Secondary substance abuse problems require particular attention in their own right - as do other associated manifestations such as depression which may respond to psychotherapy and medication.

Psycnotherapy, counseling, rap groups, family therapy, pharmacotherapy are all valuable treatment tools to be used judiciously depending on the particular clinical constellation.

Question: 2. What criteria are generally used to determine if a particular treatment approach is effective? How does the VA judge the effectiveness of various PTSD programs?

Answer: Much of the treatment for PTSD is empirical in nature, that is, clinicians have applied to the treatment of PTSD symptoms, approaches that have been found to be useful in treating these symptoms when they are manifested in other disorders. This empirical approach of using what seems to work best is common not only in the treatment of PTSD, but in other areas of medicine as well. There is no "best" treatment for PTSD because of the variation in the range and intensity of symptoms of the disorder. Some patients with PTSD have a level of symptoms such that they can be helped by purely outpatient programs. In other cases, the level of symptom severity and social-occupational disability is so severe that general psychiatry inpatient care and/or Specialized Inpatient PTSD Unit care and extended outpatient followup are required.

In the treatment of PTSD, behavioral, cognitive, existential and psychodynamic psychotherapies all have a place, as do various pharmacological approaches. Alone or in combination, these methods can reduce the disruptive symptomatology of PTSD and facilitate the reintegration of the veteran into the community.

The efficacy of a treatment or of a treatment program can only be determined by scientifically valid outcome evaluation studies. For both psychotherapeutic and pharmacological approaches, controlled studies and overall treatment efficacy (outcome) studies are first beginning to be developed. This says nothing unique about PTSD,

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rather, we are just entering the era of scientifically valid treatment efficacy and outcome studies in mental health. Until controlled outcome studies are completed, one can say only that a treatment is effective if it serves to decrease symptoms and improve patient functioning.

The CMD's Special Committee on PTSD has had preliminary talks on carrying out an outcome study on Specialized Inpatient PTSD Units. Issues of study design and sources of funding were identified as impediments to implementation. This is a task that a National Center for PTSD should be well equipped to coordinate.

While some PTSD programs have begun to develop outcome and followup activities, significant numbers of patients must be surveyed to have statistically valid results. Such studies are time consuming and costly, but plans are being considered to incorporate such evaluation activities as a routine aspect of program operations.

One measure of the effectiveness of VA programming on PTSD has been the increase in numbers of patients treated for PTSD in our VA Medical Centers. In FY 1984, there were 5,377 unique patients treated for PTSD in VA inpatient settings; in FY 1987, this number had increased to 10,108 individuals.

Question: 3. I understand that in many cases veterans with PTSD also have another psychiatric diagnosis, such as depression or substance abuse. What percentage of veterans with PTSD also have another such diagnosis? How do VA treatment programs take this into account? Is it possible to determine if the PTSD preceded or succeeded the other diagnosis? If so, how? How does the VA's adjudication of PTSD claims take this into account?

Answer: A review of the 1984 Patient Treatment Files revealed that 17.9% of patients with PTSD had a co-diagnosis of Depressive Disorder, 32% had a co-diagnosis of alcohol or substance abuse or dependence, 9.7% had a co-diagnosis of schizophrenia. Since that time, some PTSD programs have reported a much higher incidence of alcohol and/or drug abuse in their patient populations. The number of patients treated in the system for combined psychiatric and alcohol/drug abuse problems has increased from 58,966 in FY 1984 to 104,190 in FY 1987.

VA treatment programs are recognizing the increasing incidence of patients with PTSD and other diagnoses, and they are responding in a variety of ways. Because of the demands placed on patients and staff by PTSD treatment, most Specialized Inpatient PTSD Units (SIPUs) wish to avoid treating patients whose substance abuse or other psychiatric problems are of equal or greater intensity compared to their PTSD. Such patients are generally referred to

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other treatment programs for the management or resolution of the co-morbid problem before entering PTSD treatment. Recently, in response to the frequency of associated substance use disorders (alcohol and/or drugs) some SIPUs are incorporating a component of treatment for PTSD and substance abuse into their treatment program (e.g., VAMC Menlo Park). Some education for VA staff on management of PTSD and associated diagnoses has been carried out and more is planned.

Yes, it is often possible to determine if PTSD preceded or succeeded the other diagnosis. Such determinations are usually made by examination of the patient's clinical history, which reveals which symptoms (those of PTSD or those of the other diagnosis) manifested themselves first.

Adjudicators rely upon the opinions expressed by VA clinicians as documented in Compensation and Pension examination reports to determine precedence of disorders.

Question: 4. You state on page 5 of your testimony that Vet Centers are effective in treating PTSD. What is the basis for this statement? What specific studies have indicated that Vet Centers are effective in treating PTSD?

Answer: No formal study has as yet been done indicating that PTSD treatment of any type at any location is effective. With reference to counseling and psychotherapy for PTSD, which are the leading methods of treatment at vet centers and medical centers, scientific studies of such psychological treatment are very difficult to accomplish in part because of ethical barriers to establishing control groups from whom such treatment is withheld, and also in part because of the complexity and multiple specific types of psychological treatment methods. Therefore, in this area, as is the case for evaluating psychological treatment in the mental health field generally, evaluation of effectiveness must rely on outcome measures such as the following:

a. rates of recidivism, i.e., the extent to which clients are able to resume normal living wihout returning for treatment;

b. client satisfaction as expressed by individual veterans and family members at the completion of treatment; and,

c. the general standing of the treatment facility among the public and professionals in the community as measured by continuing referrals of new clients.

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Question: 5. On July 13, 1988, the Senate passed legislation (as part of H.R. 4800, the HUD and Independent Agencies Appropriations bill) which would, among other things, provide $5 million in increased funding for PTSD treatment. What is your view of this proposal? Does the VA need to direct more funding to PTSD treatment programs?

Answer: The VA has made a strong commitment to providing treatment for veterans suffering from PTSD. To that end, the VA has dedicated resources for Vet Center programs, Specialized Inpatient PTSD programs and PTSD Treatment Teams. Additional resources have been targeted as national priority training funds for training clinical staff on diagnostic and treatment issues relating to PTSD. If the additional $5 million were provided to the VA for PTSD treatment as specified in H.R. 4800, these funds could be used to enhance PTSD treatment capabilities.

Treating patients with PTSD has been a high priority for the VA and funds have been directed toward meeting these veterans' treatment needs in Vet Centers, in Specialized PTSD programs and in general psychiatry inpatient and outpatient programs. However, treating veterans with PTSD is one VA priority among many and, as such, must compete with other programs for available resources.

Question 6. Does the VA have an adequate number of properly trained and skilled staff to provide treatment for PTSD? Does VA have a difficult time recruiting and retaining staff with expertise in PTSD diagnosis and treatment?

Answer: Between FY 1984 and FY 1987, the VA carried out over 40 training sessions on PTSD each year, providing education on the diagnosis, evaluation and treatment of PTSD to an estimated 9,000 staff trainees. That this training has provided an adequate number of staff capable of diagnosing PTSD may be evidenced by the increasing number of patients diagnosed as having PTSD: from 5,377 individual patients in FY 1984 to 10,108 in FY 1987. The development of treatment skills is a more complex task than the development of diagnostic ability. Basic education in treatment has been provided in the past. Since FY 1987, and continuing into the present, educational programs with a specific and intense treatment focus are being planned and implemented. It must be noted that initial reports from the National Vietnam Veterans Readjustment Study suggest potentially large numbers of PTSD sufferers who have not received care. This study must be thoroughly evaluated before the question about "adequate" numbers of staff can be responded to accurately.

SENATOR MURKOWSKI

It is difficult to answer this question accurately with specific reference to staff skilled in PTSD care. It is clear that VA is having difficulty in recruitment and retention of psychiatrists in a number of VA medical centers across the country. PTSD Treatment Teams have experienced some difficulty in recruiting psychiatrists and other staff.

Question: 7. At present, how many veterans are being treated in the private sector on a contract basis for PTSD (under the Readjustment Counseling contract program and as authorized under section 603 of title 38, United States code)? What is the cost of the program? How does the VA ensure the quality of that treatment?

Answer: During fiscal year 1987, a total of 7,012 veterans were treated on a contract basis. For the first eight months of fiscal year 1988, a total of 4,874 veterans have been treated on a contract basis. A total of $5.4 million was obligated for these services in fiscal year 1987 and a projected $4.8 million has been planned for contract services in fiscal year 1988.

The VA ensures the quality of contract treatment by granting contract provider status only to those who qualify with an adequate level of expertise in treating PTSD and with qualifying professional credentials in a competitive bidding process. Such competitive qualifications according to credentials and expertise is an important feature of the Readjustment Counseling Service (RCS) contracts program. In addition, current contract services are rountinely evaluated for quality by RCS management through periodic site visits and through Department of Medicine and Surgery formal systematic external review program (SERP) visits. Also, quality assurance is facilitated by a requirement for periodic reviews of all cases in treatment at 15 visit intervals by the VA referring vet center staff.

Question: 8. S. 2011, as ordered reported by the Committee would, among other things, provide an entitlement for inpatient and outpatient care for Vietnam veterans with PTSD. What is the VA's position on this provision? What would be the impact of this provision in terms of both health care services and funding and claims for VA compensation? In VA statute or regulations is the VA "required" to treat any other specified disease for veterans of a single war?

Answer: The Veterans Administration does not support this provision. One of the reasons for opposing this measure is that it would be the first instance of a priority for care being given on the basis of a particular diagnosis of a disorder incurred by veterans of a single war. If PTSD treatment needs a greater priority in the VA, the agency should have the opportunity, as we testified at the recent hearing, to devise ways of providing this priority within the total health care system operated by VA, without such a legislative constraint.

SENATOR MURKOWSKI

We object to this provision further because it would treat veterans as service-connected when they have not been formerly adjudicated service-connected. Under the measure, all that is needed is that the diagnostician determine that PTSD is service-related, and that the veteran produce evidence of Vietnam service. We are concerned about the confusion which could result from veterans learning that VA will treat them for PTSD, but that they may not be eligible for compensation for the disorder.

We estimate the cost of enactment of this measure for medical care alone would be approximately $13.9 million in fiscal year 1989 and $69.5 million over the next five fiscal years.

Question: 9. Vet Center team leaders indicated during their testimony before the committee that, when a veteran applied for compensation for PTSD, "therapy was over." Their statements implied that there is some correlation between an application for monetary benefits (VA compensation) and the treatment process. Please respond to this observation from the points of view of both the Department of Medicine and Surgery and The Department of Veterans' Benefits.

Answer: The reference to therapy being over when a veteran applies for compensation was meant to apply to only a small fraction of the total number of claimants. In certain cases a veteran may misinterpret the allowance of the claim to mean that the VA agrees the veteran is disabled and the veteran then may assume the condition is permanent and not participate in treatment. The general clinical consensus (including vet center team leaders) is that obtaining allowance of a claim for compensation can have widely varying impact on veterans' treatment. In some instances there is simply no effect; in others, there can be a positive effect and the veteran actively participates in treatment to overcome the PTSD symptoms; or, some may be impacted negatively by giving up and resigning themselves to a life of disturbance with fluctuating recurring symptoms.

Vet Center

3130 Henderson Drive
Cheyenne, Wy. 82003

July 22, 1988

WRITTEN QUESTIONS FROM SENATOR SIMPSON TO

BOB MEREDITH AND THE RESPONSES

Q: HOW MANY VETERANS AND HOW MANY FAMILY MEMBERS RECEIVE COUNSELING THROUGH VET CENTERS IN WYOMING?

A: In the combined offices of Cheyenne and Casper, we are averaging approximately 380 visits per month, as of June 30, 1988. This total does not include figures from our outstation in Ft. Collins, Colorado. Also included in this figure are veterans from eras other than Vietnam who come into the two active Vet Centers. The total number of visits for FY 88 are 563 per month as of June 30, 1988.

Q: IS THERE ANY WAY FOR A VETERAN WHO LIVES IN WYOMING BUT LIVES AT SOME DISTANCE FROM CHEYENNE OR CASPER TO RECEIVE READJUSTMENT COUNSELING?

A: Yes, sir, there is. Two primary methods of service are, or will be, offered to veterans living considerable distances from our two locations. The first method of delivery of service offered is our "Outreach Program". Counselors from the Vet Center travel to the communities to see veterans. Various local community resources donate space. Outreach is also accomplished by going to veteran's residences. The second method of delivery of services is through "Contract Providers". Local community mental health professionals are contracted to provide therapy for veterans in those communities outside a reasonable distance from the two Vet Centers in Wyoming.

Q: DO YOU PERCEIVE THAT THERE IS A NEED FOR EXPANDED READJUSTMENT COUNSELING SERVICES IN WYOMING? IF SO, WHERE, AND HOW COULD THOSE SERVICES BE MOST EFFECTIVELY PROVIDED?

A: Yes, there is.

1). Currently in Wyoming there are areas which are not being served effectively. With present staffing, we are unable to provide any Readjustment Counseling to either one of the Indian Reservations in central Wyoming. Also, we have not contracted with anyone in northwestern Wyoming to provide counseling services.

2). Additional staff could be added to provide the needed services. This would enable us to continue to provide quality services at the present Vet Centers.

There is a need for specalized services in Wyoming Native American Readjustment Counselors. This specalized outreach could be accomplished by either hiring Native Americans or individuals who are aware of the cultural needs and P.T.S.D. issues.

The establishment of a facility designed expressly for the special population could provide necessary services to the Native American population.

Q: HOW MANY PEOPLE ARE EMPLOYED IN THE VET CENTER PROGRAM IN WYOMING? HOW MANY PEOPLE PROVIDE -- OR ARE QUALIFIED TO PROVIDE -- READJUSTMENT COUNSELING?

A: Currently, we have five and one-half employees:
1 Team Leader
1 Clinical Coordinator
1/2 Staff Psychologist
1 Readjustment Counselor
2 Office Managers

Currently, we have five (5) full-time counselors and one half time Psychologist on staff. Of these staff members, the Team Leader, Clinical Coordinator, Psychologist and the Readjustment Counselor are presently qualified to provide readjustment counseling services. The remaining two staff members provide support as reception and office personnel.

We have one other member presently assigned to our staff. She is currently assigned to our Ft. Collins outstation on a full-time basis.